

Ontario Task Force On Insurance

VOLUME II
APPENDICES


A Pre-Publication of the Final Report of the Ontario Task Force
on Insurance to the Minister of Financial Institutions
May, 1986



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16. The Current System of Disability Benefits in Ontario
17. Dr. Frank Sellers, "The Potential Effect of Liability Claims on the Canadian Public Health Care System: A Need for Legal Reform and/or an Alternative to Litigation for the Compensation of Persons Disabled Because of A Medical Misadventure", December 1985, A Report to the Deputy Minister, Health and Welfare Canada
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APPENDIX 1

LIST OF BRIEFS AND SUBMISSIONS

BRIEFS

Advocacy Resource Centre for the Handicapped
The Advocates' Society
Allstate Insurance Company of Canada
The Association of Canadian Insurers
The Association of Ontario Motels & Motor Inns
Association of Professional Engineers of Ontario
Automobile Protection Association
Behavioural Health Inc.
The Board of Trade of Metropolitan Toronto
Brown, Craig (University of Western Ontario)
Brown, Robert L.
Building Industry Development Board
Buset & Eyrout (Barristers & Solicitors)
Canadian Automotive Leasing Association
Canadian Bar Association (Ontario)
Canadian Chemical Producers' Association
Canadian Export Association
Canadian Independent Adjusters' Association
Canadian Institute of Actuaries
Canadian Institute of Public Real Estate Companies
The Canadian Life and Health Insurance Association
Canadian Manufacturers' Association
Canadian Medical Protective Association
Canadian Organization of Small Business
Canadian Paraplegic Association
Canadian Reinsurance Company
Consulting Engineers of Ontario
Consumers' Association of Canada (Ontario)
The Co-operators General Insurance Company
The Corporation of the City of North Bay
The Corporation of the City of Brantford
F & W Property Management Ltd.
Facility Association

Friedland, Seymour
 Futerman, Jack
 Hogan, Michael A.
 Income Maintenance for the Handicapped
 Insurance Brokers' Association of Ontario, Toronto Insurance Conference
 The Insurance Bureau of Canada
 Insurers' Advisory Organization of Canada
 Kenora District Municipal Association
 Marsh & McLennan Limited
 The Mercantile & General Reinsurance Company of Canada
 Ministry of the Attorney-General
 Ministry of Industry, Trade and Technology
 Ministry of Transportation and Communications
 Municipal Affairs Insurance Advisory Committee
 Municipal Electric Association
 The Municipality of Metropolitan Toronto
 McKellar Structured Settlements Inc.
 McMaster University Faculty of Health Sciences
 McTavish, Wilson A.
 National Insurance Managers Inc.
 New Democratic Party
 Niagara Falls Taxi Ltd.
 Northern Frontier General Insurance Company
 Northern Ontario Tourist Outfitters Association
 The Ontario Association for the Mentally Retarded
 Ontario Association of Architects
 Ontario Automobile Dealer Association
 Ontario Camping Association
 Ontario Chamber of Commerce
 Ontario Federation of Agriculture
 Ontario Fruit and Vegetable Growers' Association
 Ontario Good Roads Association
 Ontario Greenhouse Vegetable Producers Marketing Board
 Ontario Hospital Association
 Ontario March of Dimes
 Ontario Motor Coach Association
 The Ontario Mutual Insurance Association
 Ontario Natural Gas Association

Ontario Petroleum Association
 Ontario Petroleum Institute Inc.
 Ontario Risk and Insurance Management Society
 Ontario Sailing Association
 Ontario Sports Medicine and Safety Advisory Board
 Ontario Trucking Association
 Ontario Water Ski Association
 Patients' Rights Association
 Pensa, Claude
 Philpott, Lorne (H.L. Staebler Company)
 Pool Insurance Managers Ltd.
 The Professional Liability Insurance Program - A Plan for Ontario Dentists
 Reed Stenhouse
 Regional, District and Metropolitan Solicitors' Group
 Regional Municipality of Niagara
 Registered Nurses' Association of Ontario
 Reinsurance Research Council
 Ross, Angus H.
 St. John Ambulance
 Siskind, Cromarty (Barristers & Solicitors)
 Society of Fellows, Insurance Institute of Canada
 State Farm Insurance Companies
 Tourism Ontario Inc.
 Trial Lawyers Association of British Columbia
 Urban Finance Officers Association of Ontario
 Wellington Insurance Company
 Western General Mutual Insurance Company

SUBMISSIONS - ASSOCIATIONS

Academy of Defensive Driving
 Air Products Division Stearns Catalytic Ltd.
 Algoma Farmers Market
 Association of Municipalities of Ontario
 Canadian Association of Exhibitions
 Canadian Association of Movers
 Canadian Association of Municipalities
 Canadian Federation of Independent Business
 Canadian Towing Society
 CAPS Nursing Service
 Catholic Youth Organization
 City of Port Colborne
 Consumer Chemical Limited
 The Corporation of the Town of Campbellford
 County of Lambton
 Del Equipment Limited
 Denny Bus Lines
 Duncan Insurance Services Limited
 Electrical and Electronic Manufacturers Association of Canada
 Equicon Engineering Limited
 Federation of Northern Ontario Municipalities
 Halton Taxi Services
 Hunter, Winn Underwriting Management Limited
 Intrex Commodities Inc.
 J.B.M. Murray Ltd.
 The Law Society of Upper Canada
 Lincoln County Roman Catholic Separate School Board
 L-Tec Welding & Cutting Systems
 Mechanical Contractors Association (Ontario)
 Minden, Gross, Graftstein & Greenstein (Barristers and Solicitors)
 Motorcycle & Moped Industry Council
 Northwestern Ontario Municipal Association
 Northern Ontario Tourist Outfitters Association
 Ontario Advisory Council on the Physically Handicapped
 Ontario Equestrian Federation Inc.
 Ontario Horse Trials Association

Ontario Hotel & Motel Association
Ontario Law Reform Commission
Ontario Motorcycle Dealers' Association
Ontario Ski Resorts Association
Port Colborne General Hospital
Public Utilities Commission of the City of Kingston
Quinte Insulators Ltd.
Registered Insurance Brokers of Ontario
Reliable Taxi Newmarket (1978) Ltd.
Royal Insurance Canada
School Bus Operators' Association of Ontario
Simcoe & Erie Group
Sorge Insurance Brokers Ltd.
Toronto Insurance Conference
Township of Hope
Township of Ignace
The United Senior Citizens of Ontario
Vanderhout Insurance Limited
Whisper Trading Ltd.
Willowgrove
Zehr Insurance Brokers Ltd.

McBride, Ron
Munro, The Honourable Lily
Noel, Rodney
Phillips, Sanford
Piekutowski, R.
Polley, Ken
Prager, Lothar M.
Reeve, Peter E.
Riddell, The Honourable Jack
Riddle, Gerry
Ringer, Howard
Sanderson, John A.
Sands, W. George
Scuro, Carol
Searle, James D.
Tatomir, John
Tawse, W.J.
Wilson, Dave
Yan, Andrew

APPENDIX 2

RESEARCH STUDIES AND SURVEY PAPERS

Clendenning, E. Wayne, "A Discussion of the Implications for General Insurance Actuaries Arising from Recent Financial Sector Reports and Legislation".

Coopers & Lybrand, "The Financial Performance of the Property and Casualty Insurers"; "Review of Trends and Cycles in Availability and Price of General Insurance Services"; and "Summary Paper: Causes of and Prospects for the Current Cycles in Availability and Price, Financial Performance and Reserve Experience in the General Insurance Industry".

Krossel, Martin, "The General Insurance Industry and Financial Conglomerates".

Mathewson, Frank and Winter, Ralph, "The Market for Property and Casualty Insurance in Ontario".

Osborne, Philip, "A Critical Evaluation of Liability Insurance, Litigation and Personal Injury Compensation: The Lessons and Choices for Ontario".

Rea, Sam, "Economic Analysis of Fault and No-Fault Systems".

Trebilcock, Michael J., "The Insurance-Deterrence Dilemma of Modern Tort Law: Trends in North American Tort Law and Their Implications for the Current Liability Crisis".

Tuohy, Carolyn and Chandler, Marsha, "The Role of Government in the Insurance Arena In Ontario: A Political Analysis".

Woods Gordon Management Consultants: "Research Paper - Automobile Rating Classifications"; "Research Paper - The Distribution System"; "Research Paper - Government Presence in Ratemaking"; "Research Paper - Liability Insurance"; and "Research Paper - The Claims-Made Liability Policy Form".

APPENDIX 3

GLOSSARY OF INSURANCE TERMS

Abandonment

To give up rights and duties in the item insured. All insurance policies, except Marine, forbid abandonment by the insured of the article insured without the consent of the insurance company.

Act of God

A direct, sudden and irresistible act of nature, such as could not have been foreseen or, if foreseen, its effect could not have been prevented - an inevitable accident, e.g., flood, earthquake, etc.

Actual Cash Value

The current value of an insured article at the time of a loss. This may be the cost of replacing the article with a similar model in similar condition. It may, however, involve the price of the article plus any appreciation or less depreciation since its purchase.

Actuary

A person trained in the "principle of large numbers" and the "theory of probability", who calculates the proper premium rates based on experience and often considers the accuracy of the assessment of reserves.

Adjuster

The person who investigates insured losses and negotiates the settlement of claims on behalf of the insurer. Public adjuster is one who, for a fee, represents policyholders in the adjustment of their losses with insurance companies.

Adjustment

The process of arriving at the settlement of a claim. It may consist of a series of computations in an uncomplicated fire loss or it may involve discussions of the degree of liability, quantum of damages and other matters in problem liability claims.

Agent

The **independent agent** is an independent businessman who represents two or more insurance companies under contract in a sales and service capacity and who is paid on a commission basis. The **exclusive agent** represents only one company usually on a commission basis. The **direct writer** is the salaried or commissioned employee of a single company. Agents are licensed in the province(s) in which they operate.

Aggregate

The dollar amount of insurance coverage during one specified period, usually 12 months, for all insurance losses sustained under a policy during such period.

Appraiser

The person called upon to establish quantum or the extent of material loss resulting from a claim, or to assist in the underwriting of a risk, usually recognized as an expert in his field of endeavour, i.e., real estate, gemology, automotive or industrial equipment. The **independent appraiser** is an independent businessman who represents many insurance companies, reporting to the adjuster or company. The **staff appraiser** represents one company exclusively and reports directly to that company. The **adjuster's appraiser** usually represents one independent adjuster and reports directly to that adjuster.

Arbitration Clause

Language providing a means of resolving differences between the company and the policyholder without litigation. Usually, each party appoints an arbiter. The two thus appointed select a third arbiter, or umpire, and a majority decision of the three becomes binding on the parties to the arbitration proceedings.

Assignment

The transfer of an interest from one party to another. Insurance policies are personal contracts and are not transferable except by consent of the insurance company.

Binder

An agreement to cover a risk pending the issuance of a policy. It is also known as a "cover note".

Blanket Rate

Uniform premium rate for everything insured under one policy. It may involve several properties.

Boiler and Machinery Insurance

Coverage for loss arising out of the operation of pressure, mechanical and electrical equipment. It may cover loss suffered by the boiler and machinery itself and may include damage done to other property, as well as business interruption losses.

Bond

A bond issued by an insurance company generally protects an individual or corporation, known as an obligee, from loss arising out of the acts or failure of another, known as the principal. Basically there are two types of bonds - surety bonds and fidelity bonds.

Broker

A marketing specialist who represents buyers of property and liability insurance and who deals with either agents or companies in arranging for the coverage required by the customer. Like the agent, the broker is licensed in the province or provinces in which he conducts his business.

Building Rate

The fire insurance rate on a building (real property), as distinct from the rate on the stock or contents, etc.

Cancellation

The termination of the policy before the end of a policy period. Usually if the company cancels the policy, the insured is entitled to a pro rata return of premium for the unused portion of the policy. If the insured cancels, he is entitled to a reduced refund of premium.

Casualty Insurance

The group of coverages which includes insurance against liability claims and almost all other types except fire, marine and life.

Claim

The demand for payment under a policy as a result of loss or damage sustained by the insured or a third party.

Claim Reserve

The amount of money set aside by an insurance company for a reported claim that has not been settled.

Co-Insurance

A clause in an insurance policy providing for the sharing of the loss unless the policyholder maintains insurance on his property or contents up to a stipulated percentage of its value.

Comprehensive Automobile Insurance

This type of automobile insurance provides coverage to repair your car when it is damaged in circumstances other than by a collision, e.g., fire, theft, vandalism, glass breakage, etc.

Compulsory Automobile Insurance

Many jurisdictions in Canada and the U.S.A. require evidence of the existence of valid third party liability automobile insurance before a motor vehicle permit will be issued or renewed. In some jurisdictions, accident benefits and collision coverages may also be compulsory.

Concurrent Insurance

Where two or more insurance policies are alike in all material aspects, both insurance policies apply concurrently to the loss and are known as concurrent insurance.

Contents Rate

The rate set for insurance on the contents of a property rather than the building itself.

Cover Note

An agreement to cover a risk pending the issuance of a policy. It is also known as a "binder".

Daily Report

The insurance company's (or agent's) record of the policy. It usually includes the application, the carbon copy of the typewritten parts of the policy and the endorsements. It omits the cover form and lengthy portions of the policy which are standard to the particular company's policy of that type.

Damages

A sum of money claimed or awarded as compensation for loss or injury.

Deductible Clause

Some policies are written to pay only after the policyholder has himself suffered an agreed amount of loss. The amount which he must lose first is "deducted" from the total of the damage to determine the amount the company must pay and thus becomes the "deductible".

Effective Date

The date at which the protection becomes effective.

Endorsement

An endorsement is a modification which is added or attached to an existing policy.

Estoppel

The legal bar raised by one's own actions against asserting a right which once existed. See also "Waiver".

Excess Insurance

Excess insurance means insurance which becomes effective only when the loss is in excess of a certain amount or where it is in excess of the basic policy.

Ex Gratia Payment

A payment made for which the company is not liable under the terms of its policy.

Expense Ratio

The percentage of premium used to pay all the costs of acquiring, writing and servicing insurance.

Expiration

The date set in the policy when it is to expire.

Exposure

The hazard threatening a risk because of external or internal physical conditions.

Extended Coverage

An endorsement that enlarges the coverage afforded by the policy. In fire policies, the "Extended Coverage" adds still more perils such as accidental leakage of plumbing and heating systems, vandalism, etc.

Financial Responsibility Law

A statute which requires motorists to be able to establish their financial ability to pay losses up to a certain minimum dollar limit. The most usual form of proof is an insurance policy. This law assures availability of money to pay damages arising from an automobile accident for which the policyholder is legally liable.

Floater Policy

A policy covering the same risk at a number of unspecified locations, and usually including suggestions of goods being frequently moved from one location to another, e.g., Fur Floater, Jewellery Floater.

Form

Generally the printed part of a policy is referred to as the "form". There are printed parts for most policies and these are frequently identified as the "fire form", "liability form", etc.

Franchise

A provision in an insurance policy whereby the insured pays claims up to a predetermined amount. If, however, any loss exceeds that amount, then the insurance company assumes responsibility for the full amount of the loss including the franchise amount. (See "Deductible".)

Green Book

An annual automobile experience exhibit produced for government by the statistical arm of Insurance Bureau of Canada.

Guaranteed Cost

Premium charged on a prospective basis which may be fixed or adjustable on a specified rating basis but never on the basis of loss experience.

Homeowner's Policy

A package policy designed to cover the various risks of a homeowner. Coverages for the building, personal property and legal liability are incorporated into one contract.

Insurable Interest

To make insurance policies legal and valid, the insured must possess such an interest in the subject of insurance as may be sufficient to involve him in a monetary loss, should the subject be damaged or destroyed. In other words, if he has a direct monetary interest in the property to be insured, or the risk to which he is exposed, he has insurable interest. This interest may be of various characters - it may be that of an owner, a lessee, a guardian, a bailee, an executor, an administrator, a bailiff, a sheriff or a creditor. As long as there is a real monetary interest, there is an insurable interest.

Insurance

The undertaking to indemnify another person against loss or liability for loss in respect of specified perils or upon the happening of a specified event.

Insured

One who transfers a risk to another. The person named in the agreement of indemnity from an insurance company (or person) affording them indemnity from perils as set out therein. Interchangeable with "assured".

Insurer

The insurance company which has agreed to accept the risk and to supply the indemnity to an insured in the event of loss.

Insuring Clause

The part of the insurance policy which sets out the specific agreement to protect against the particular peril for which the insurance is purchased. It is an essential part of all insurance contracts.

Legal Liability

The responsibility imposed under law upon one person to another whether by common law, statute or contract.

Liability Insurance

Provides protection for the insured against loss arising out of his legal liability resulting from injuries to other persons or damage to their property.

Lloyd's

A broad term used to designate a group or groups of individuals, known as syndicates, not insurance corporations or companies, assuming liability through an underwriter. Each individual independently assumes a proportionate part of the insurance accepted by the underwriter.

Loss or Damage

Loss is technically distinguished from damage in fire insurance when all or any portion of the property insured is consumed. "Loss" designates that portion which is entirely consumed, while "damage" designates that part of the property which is not consumed, but remains after a fire in a damaged condition.

Loss Ratio

Proportionate relationship of incurred losses to earned premiums expressed as a percentage.

Malpractice Insurance

Coverage afforded to a professional practitioner, such as a doctor or lawyer, against liability claims for damages resulting from alleged negligence in the performance of the insured's services.

Merit Rating

A system of rating whereby the insured with a good experience obtains benefits at a lower rate. Commonly used in automobile insurance where a driver who is accident-free for a certain period of time is given a discount from a listed rate he would otherwise pay.

Mortgage Clause

A policy provision containing an agreement to notify the mortgage holder of changes in the policy, to have his rights unaffected by acts or omissions of the insured, and to have every loss payable to him as his interest may appear.

No Fault (Automobile)

A common description of insurance which will pay the insured person and others involved in accidents without determining his degree of fault. Examples are collision insurance and the limited accident benefits.

Open Cover

An agreement under which risks of a specified category may be declared and insured. Most frequently used in marine insurance.

Package Policy

A combination of the coverages of two or more separate policies in one contract with one premium.

Peril

This term refers to the causes of possible loss in the property field, for instance, fire, windstorm, collision and hail. In the casualty field, the term "hazard" is more frequently used.

Policy

The actual contract of insurance with all its details.

Pool

An organization of insurers or reinsurers through which particular types of risks are underwritten with premiums, losses and expenses shared in agreed ratios.

Premium

The sum of money paid by an insured in consideration of the acceptance of a risk by an insurer. **Earned premium** is the proportion of the total premium which would pay for insurance from the inception date of the policy until the particular date at which it is desired to calculate the earned premium. **Direct premium** is the total premium received from all sources including reinsurance assumed from other companies. **Written premium** is the total amount of premium collected on that class of business or on all classes of business.

Premium Deposit

When the terms of a policy provide that the final earned premium be determined at some time after the policy itself has been written, companies may require tentative or deposit premiums at the beginning which are re-adjusted when the actual earned charge has been later determined.

Proof of Loss

The written document signed by the insured, formally making a claim against the insurer.

Property Insurance

Provides financial protection against loss or damage to the insured's property caused by such perils as fire, windstorm, hail, explosion, aircraft, motor vehicles, vandalism, malicious mischief, riot and civil commotion, and smoke.

Rating Bureau

A non-profit organization of insurance companies formed to promulgate rates for its members and subscribers.

Recovery

The amount of loss which an insurance company gets back from reinsurance, salvage or by subrogation against the person responsible for the loss.

Reinsurance

The process whereby a company may share its risk with another, paying to such sharing company a portion of the premium it receives. Loss payments are made by the company accepting the reinsurance directly to the producing company, not to the policyholder.

Renewal Certificates

The form used to change the expiry date of the contract.

Replacement Cost Insurance

Insurance which pays the full value of damaged or destroyed property without taking depreciation into consideration.

Reserve

See "Claim Reserve" and "Unearned Premium Reserve".

Retrospective Rating

A plan or method which permits adjustment of the final premium on the basis of the actual loss experience under the subject policy, subject to minimum and maximum limits.

Self-Insurer

An individual, partnership or corporation who retains all or part of the risk for its own account and purchases an excess of loss cover to protect itself in the event of a catastrophe.

Subrogation

When a company pays a loss for which some person other than the policyholder is responsible, the company's right to recover its loss from the guilty party is the right of subrogation.

Suretyship

(1) The function of being a surety; (2) Stated in its simplest terms, suretyship embraces all forms of obligations to pay the debt or to answer for the default of another.

Syndicate

In insurance, usually a group of companies or other underwriters who join together to insure certain property which may be of such value, or of such high hazard, or so expensive to underwrite that it can be done on a co-operative basis more efficiently. (See "Lloyd's".)

Term

The period of time from the inception to the termination of an insurance contract.

Third Party

The claimant under a liability policy. So called because he is not one of the two parties - insured and insurer - who enter into the insurance contract which pays his claim.

Tort

An act or omission that may give rise to an action in damages.

Umbrella Policy

A form of excess liability insurance available to corporations and individuals protecting them against claims in excess of the limits of their basic policies, or for claims not covered by their insurance program.

Underwriter

The insurance company or group that underwrites or insures a particular risk. It is also used to identify the individual in the company who accepts or rejects business in the particular line he specializes in, and in this way, chooses risks his principals are prepared to consider.

Unearned Premium Reserve

Insurance premiums are paid in advance. A company, however, "earns" the premium only as fast as time elapses. Yesterday's premium is earned. Tomorrow's premium is unearned. The unearned premium reserve is the sum of all the unearned premiums of all the unexpired policies that a company has on its books.

Void or Voidable

A contract is void when it is destitute of all legal effect. A voidable contract is one which can be made void at the option of one of the parties.

Waiver

An intentional relinquishing of a known right. A waiver under a policy is required to be clearly expressed and in writing. See also "Estoppel".

Note: The **Glossary of Insurance Terms** published by the Insurance Institute of Canada has been reprinted with permission.

APPENDIX 4

BASIC TYPES OF PROPERTY AND CASUALTY INSURANCE*

I PERSONAL PROPERTY INSURANCE

II COMMERCIAL PROPERTY INSURANCE

1. Fire and allied lines
2. Business interruption
3. Crime insurance
4. Cargo insurance
5. Miscellaneous property coverages:
 - crop insurance, livestock and bloodstock insurance, floater policies, weather insurance, glass insurance, builders' risk policies, specialized property insurances

III LIABILITY INSURANCE

1. Comprehensive general liability (for all basic liability hazards of a business except for contractual liability)
 - a) Bodily injury and property damage liability.
 - b) Products liability
 - to third parties for losses involving injury or damage by products that either a manufacturer, wholesaler or retailer deals in. Legal liability is based on negligence or breach of warranty.
 - c) Employer's liability and voluntary compensation (for injury to employees not covered by workers' compensation).
2. Professional liability
 - a) Errors and omissions insurance
 - b) Malpractice insurance
3. Other business liability coverages
 - a) Contractual liability
 - b) Directors' and officers' liability
 - c) Owners', landlords' and tenants' liability
4. Excess or umbrella liability (to provide catastrophe liability protection).
5. Surety Bonds.
6. Fidelity bonds.

* These are described in much greater but very useful detail in Appendix F to the Third Report of The Select Committee on Company Law on the General Insurance Industry, 1979.

IV "OTHER LINES" INSURANCE

1. Marine insurance
2. Aircraft insurance
3. Boiler and machine insurance
4. Mortgage insurance
5. Credit insurance
6. Title insurance

APPENDIX 5

STRUCTURE AND OPERATION OF THE PROPERTY AND CASUALTY INSURANCE INDUSTRY IN ONTARIO

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RISK AND INSURANCE

The basic concept of risk is that it reflects the likelihood of a loss to an individual, group or corporation. Risks may be evaluated by considering the probability of events or occurrences which give rise to losses, and by considering separately the size and incidences of losses attached to those events. The events or occurrences may arise from many different hazards, from which perils such as fire, theft, etc. may arise, resulting in losses. Liability claims result from the wrongdoings of individuals, firms, or corporations in either an intentional manner or by negligence. Liability claims may also arise from failure or violation to perform contractual obligations.

The consequence of failure to provide for risks is generally demonstrated by economic loss, which can be so severe as to destroy the financial viability of an individual or corporation.

Risk Control and Reduction

Risk management has as its basic goal the reduction of the potential for loss before it occurs through a process of identification, measurement and evaluation, reduction or elimination of the risk, and financing the risk.

All individuals, groups and governments have opportunities to reduce the probability of events or occurrences which give rise to losses and to reduce the size of losses when they occur. Programs of driver training, traffic safety, and even improved maintenance of streets become programs of risk control, thereby reducing the probabilities of events or occurrences which give rise to losses.

There are organizations dedicated to these objects. These include the Ontario Risk and Insurance Management Society, which is a chapter of the Risk Insurance Management Society - a non-profit association for risk and insurance managers of commercial and industrial enterprises, public entities, non-profit organizations, and service industries. While ORIMS represents the majority of major corporations in Canada, smaller businesses and service organizations are included as well.

The Canadian Industrial Risk Insurance Association comprises some 30 insurance companies to provide a facility for wide participation of Canadian insurers in a risk-sharing mechanism, which emphasizes co-operation in loss reduction services.

There is also the Factory Mutual System, consisting of three insurance companies that provide a similar facility.

The Insurers' Advisory Organization of Canada, currently funded by some 52 groups of general insurance companies who write more than 50% of the fire and casualty insurance business in Canada, provides technical services to its members. Some of these services can be identified as: loss prevention and control - which prevent or minimize loss, including fire protection, safety, security and loss control engineering; individual risk instruction; public fire protection surveys; and the operation of a school of loss control technology. The IAO offers a risk evaluation service which develops information needed by insurers to determine premium hazards, which reflect variations in the degree of risk or hazard.

Even with these activities, there are many groups in society that are not represented or affected by these services; and it can correspondingly be seen that many opportunities exist for the development of risk reduction and control measures.

The Fundamental Basis of Insurance

Insurance in its basic form is a contractual undertaking, under which some or all of the risk of economic losses are transferred to an insurer who, for a premium, promises to compensate the insured for the losses resulting from the specified risks in the contract. The insured therefore can, by paying a premium, accept the certain cost of the premium in exchange for the transfer of a potential individual loss if the peril insured against should arise. To the person insured, though the probability of peril may be very small, the individual losses could be large or catastrophic if the peril occurred and the individual had to bear the whole loss. For an insured to enter into such an agreement, a large number of agreements covering similar risk characteristics are required. By combining many risk exposures, it is possible to predict the collective losses and to do so, in some instances, quite accurately. The underlying principle is the law of large numbers, which, in the context of insurance, states that with an increasing number of risk exposures, the actual losses approach their expected value quite closely. The expected collective loss is then shared proportionally by all insured, in the form of premiums. The insureds also bear the cost, through their premiums, of running the system.

Presupposing that adequate capacity exists to provide insurance coverages, the availability of insurance comes into question when it is not possible to predict the collective losses for a particular group of risks with sufficient accuracy. In the case of new risks, for which there is not enough experience to develop a probability of distribution of events, there is a reluctance to insure. When off-shore drilling was started in the North Sea, the probability of loss of drilling rigs in severe storms was too imprecise in calculation, with the result that insurance was only available from a relatively few insurers at very high prices.

Changes in circumstances or practice may also result in a loss distribution from various events not being calculable with sufficient precision. The current concern with respect to product liability risks in the United States is that these risks may have become so unpredictable in recent years that whatever coverage remains from a few insurers is available only at very high prices. In addition, there may be so much uncertainty surrounding a risk or the magnitude thereof that no private insurance pool, however large, can entertain the writing of such risks. An example is earthquake damage in Japan or civil war damage in Lebanon.

Transaction costs payable by the insurer may cause risks to be insurable in practice, although not in principle. Shifts in legal practice and costs, if quite uncertain in their impact, could lead to some risks being uninsurable for a time.

In a competitive, market-driven, profit-driven system, if sufficient expectations of safe and profitable insurance undertakings for various risks cannot be found, then they will be uninsurable or difficult to insure. Government regulation that might restrict expansion or control the price of insurance service may make markets unprofitable, though they would not be fundamentally so.

The Insurance Process

First-Line Insurance. First-line insurers are those who formally enter into the primary insurance contract with an insured. A large proportion of such contracts are not negotiated directly between the insured and the insurer, but are entered into and administered through a network of agents and brokers. A substantial proportion of the contracts are entered into by what are called direct writers, that is, by insureds dealing with the exclusive agents of an insurer (in Ontario, Allstate, the Co-operators and State Farm are the best known of the direct writers). The first-line insurers come in a variety of institutional forms in Ontario: joint-stock companies, mutuals, co-operatives, reciprocals and pools. Some are Canadian-chartered, some Ontario-chartered, some foreign-chartered.

The first-line insurers may pass part of the risk they enter into in the first instance to reinsurers, in return for a share of the premium income. An elaborate network of reinsurance, through various institutional forms in various parts of the world, may share risks in back of the initial reinsurance arrangement of a first-line insurer. But more of this later.

Returning to the first-line insurers, generally speaking they enter into contracts in which they receive premiums early in the life of the contract, earn them over the life of the contract, meet claims later in the life of the contract or later than the premium year, and meet expenses during and after the contract. For this reason, the insurer typically has an investment fund generated from the lags between the timing of the receipt of, and the timing of the expenses and payment of claims from which investment income can arise in the first instance in the hands of the insurer. The insurer also has some earning assets from the capital and surplus supplied by the owners of the institution, from which a second source of investment income arises. These flows are illustrated in Figure 4.1. In any given year the balance between the premium income and all expenses (commissions, administration, sales costs, claims costs and claims settlement expenses) is the underwriting profit or loss. The ratio of all such outlays, including charges to reserves, is called the operating ratio. The claim costs include claims paid, additions to reserves for claims pending but not paid, and additions to reserves for claims incurred but not received. The pre-tax ultimate bottom line in any given year is the sum of the underwriting loss or profit plus investment income on the lag funds and on the investment fund arising from capital and surplus (and includes capital gains or losses realized). The typical general insurance institution is primarily a risk intermediary both across individuals and across time, and a financial intermediary between liabilities of one time and liquidity and assets of other times and liquidities.

The profit or loss of an insurance organization in any year is an amalgam of the bits of profit or loss arising from bits of underwriting business entered into in each of many years, the current one and many previous ones. In year x , for example, there may be a bit of profit or loss arising from the income, expense and claims business in year x arising from business within year $x-y$; likewise for year $x-y+1$, $x-y+2$, and so on, up to business within year x itself (y may be many years, ten or more, in which the undertakings are referred to as having long-tails). Thus, in year x , the overall profit or loss could be the result of a complex mix of profits and losses in that year arising from the results in that year of many years of underwriting. As a result, many possibilities arise. A company could appear profitable in year x , despite its recent experience being unprofitable, the losses being offset by the completion of tail transactions from the past. Conversely, a company could show losses in year x , when in fact year x and other recent transactions are profitable, though these profits are overwhelmed by the completion of loss business emanating from the tail.

The Reinsurance Process. It is standard practice for first-line insurers to pass on or to "cede" a portion of their risks to a network of reinsurers, the reinsurers accepting a portion of the risk in return for a portion of the premium income. Many different arrangements may be made, in bulk or case by case, with various deductibles and layers, and through various channels. These need not be examined at this point. But it is worth noting that first-line insurers may engage both in ceding to and accepting contracts from reinsurance networks, depending on the mix of risks which they consider to be appropriate. When the first-line insurer has claims to settle and pay, the reinsurer will share in the funding under the terms of the reinsurance contracts. The reinsurer's share of the claim may be small or large depending on the nature of the occurrence, the size of the claim and the terms of the contract.

Brokers and Agents. The vast majority of the public in Ontario meets the insurance industry through brokers or agents. Brokers may represent any number of insurers who will accept their business. They are registered under a self-governing statute, called the Registered Insurance Brokers Act of Ontario. Agents are exclusive to the company who appoints them and are licensed under the Insurance Act of Ontario.

Brokers account for about 30% of the placement of the market, compared to some 20% for direct writers such as Allstate, State Farm and The Co-operators. To a large degree, direct writers only engage in personal lines business.

Brokers are independent businessmen, who maintain their own offices throughout the province and hold themselves out to shop the market. They are paid on a percentage commission basis. Agents for direct writers work in a variety of ways and may be housed by their insurer and paid on a form of commission.

In 1984, commission and profit commission paid by insurers, for the total of personal lines, property, automobile, and other classes of insurance, amounted to 17.6% of the premiums received. For the direct writers, the commission payable constituted 5.1% of the premium received.

Main Lines of Property and Casualty Insurance

A useful summary of the main lines of property and casualty insurance is contained in the Fact Book of the Insurance Bureau of Canada. In part, it reads:

- o Automobile Insurance (nearly 50% of premium income)
- o Property Insurance (nearly 40% of premium income)

Includes: fire, personal property, earthquake, explosion, forgery, inland transportation, livestock, plate glass, real property, theft, weather, windstorm.

Although property insurance covers buildings and contents, it also includes a number of other risks that are part of package policies or purchased separately. These coverages include personal liability for homeowners and tenants, business interruption insurance for businesses, temporary accommodation costs, etc.

- o Liability Insurance (about 8% of premium income)

This coverage protects the insured for his legal liability to others for injury, death and/or damage to their property caused through or by the insured person's occupation or personal activities. It includes the increasingly important class known as Products Liability, which protects the public for injury suffered from the use of goods and services.

- o Casualty Insurance (about 5% of premium income)

- Surety and fidelity
- Boiler and machinery insurance
- Marine and aircraft insurance

Conventionally, the insurance is also subdivided another way, into personal lines (personal automobile and property) and commercial lines (commercial automobile, commercial property, liability and casualty insurance).

General Characteristics of Property and Casualty Insurance Industry in Ontario

The insurers operating in Canada are a mixture of Canadian and foreign-incorporated bodies which are licensed to operate in Canada. Canadian incorporation may be under federal or provincial authority. No matter what the federal government's incorporation or licensing may be for insurers, provincial licenses are required for the provinces in which they operate.

Except for the insurers which are incorporated by a province (a minority of bodies both by numbers and size of operations), insurers in Canada are subject to both federal and provincial regulation. Though subject from time to time to jurisdictional "tugs of war" and disputes regarding the division of powers, both levels of government have by now such entrenched positions that concurrent jurisdiction is the best short description of the regulatory authority. De facto, the central concern of federal regulation is with the solvency of insurance companies and matters closely related thereto. The central concern of provincial regulation is with the provision of services at reasonable prices and with reasonable certainty and efficiency of delivery to customers.

As stated, in Ontario the delivery of insurance services is by a group of insurers to insureds through a decentralized market system consisting mainly of brokers and agents, and to a lesser extent through agents of direct selling insurers. Much of the cost and much of the effectiveness (for good or bad) thus depends upon the agent and broker system, and the intermediaries of adjusters.

At first impression, the industry structure among first-line insurers is predominantly atomistically competitive in most lines, but with a paradoxically concentrated structure in a few other lines. Over 150 companies compete in the automobile insurance sector; about 100 compete in the business of personal lines property insurance. These two segments make up more than 70% of the total premium writing. At the other end of the spectrum, at the time of the Task Force's work, there were two "markets" for municipal liability insurance, and two "markets" for hospital liability insurance. The large numbers in automobile and personal property lines exaggerate somewhat the atomization of the industry, because within the sectors a considerable measure of selectivity of

niches within the insuring activity exists. Nevertheless, extreme measures of competition exist alongside narrow ranges of alternatives elsewhere.

Entry and exit to the industry have been very easy, both for Canadian corporations and for foreign companies.

Risk retention among first-line insurers has varied a good deal in recent years. The conventional wisdom among the old guard of the industries is that the first-line insurers should keep a large measure of risk retention, 50% more or less, depending on the line of activity and the nature of the risk. Some companies have operated in the last decade at much lower levels, some keeping such low levels at times as to be labelled "fronting companies", hardly more than brokers. Several companies which operated in this way have failed, and the conventional wisdom of the moment is to legislate higher levels of risk retention; beyond that, to attempt by suasion to have the first-line insurers operate to higher-than-legal-minimum ratios of risk retention.

It is generally agreed, at least up to now, there have been limited economies of scale and scope in the general insurance business, especially in view of the possibilities of contracting out so many supporting services on favourable terms (services such as gathering business, administering investments, adjusting claims, settling claims and arranging legal services).

While direct sellers have increased and continue to increase their share of the personal lines of property and casualty insurance in Ontario, direct sellers have not had a large percentage of this business in commercial lines and in liability insurance.

The Fundamental Equation

The central equation governing property and casualty insurance in Ontario is the same as that which applies everywhere else. That is:

$$\text{Premiums} + \text{Investment Income} = \text{Claims} + \text{Expenses.}$$

It follows, therefore, that to keep premiums low in relation to the service and claims provided, it is necessary to meet legitimate claims fairly and promptly with minimum expense.

It further follows that for a given level of claims and investment income, every dollar extra of expenses is a dollar extra of premium cost for insureds.

Expenses or transaction costs are far from being a trivial part of the premium dollar. Depending on the particular line of insurance, the averages range from 20% to 50%, with expenses for individual cases being both more or less of this range.

Expenses or transaction costs may well be excessive in relation to the level and quality of service provided. These expenses or transaction costs are myriad, and comprise:

1. The cost of acquiring insurance contracts by insurers, being brokers or agents' commissions, advertising and marketing and the cost of organizing and operating a sales network.

2. The cost of administering, monitoring and servicing insurance contracts.
3. The cost of identifying, determining and settling claims, including legal costs.
4. The cost of meeting regulatory requirements.
5. The cost of investment administration, which might be netted against investment income.
6. The cost of legal and other services to claimants, borne by claimants mainly out of claims or their own resources.
7. Court costs, partly borne by governments.

Some Important Details of the Structure in Ontario

In general, the property and casualty insurance industry provides two distinct types of coverage. By contract, they insure property against definable loss. By separate agreement or contract, they insure individuals, firms and corporations against liability, imposed by law, in connection with safe performance of goods and services provided by their named insured. The safe performance of such goods and services is determined by the appropriate courts, based on the principles of negligence as established under the common law and as modified by legislative enactments, such as the Negligence Act.

The one exception to this general division, with respect to liability insurance, is with regard to automobile insurance and the accident benefits coverage, mandated by legislation and provided in all contracts. Accident benefits are a form of no-fault insurance, where covered persons are entitled to claim for medical rehabilitation and funeral expenses, death benefits, and loss-of-income payments. Accordingly, in this area there is a mixed no-fault, tort system whereby the innocent victim, who as an insured not receiving a no-fault benefit, is entitled to direct payments forthwith from his own insurer. The amounts which he receives will be deducted from any award made by a court, where duplicate payments would result. This functions to provide a prompt payment system to the victim. It follows that the wrongdoer who is entitled to receive such no-fault payments does so regardless of his fault.

In all instances where the victim claims compensation or damages against a wrongdoer, redress must be had to the court system in Ontario, based upon the existing law of negligence. The wrongdoer who has protected himself and his assets by the purchase of insurance will be cognizant of the fact that this protection entitles him to a legal defence where appropriate, to be paid by his insurer, and also to indemnification to the extent of the limit, as provided in the insuring agreement. Up to the present time, the contractual limits of the policies have been readily attainable by the insured and, in practice, most brokers have been able to recommend and obtain limits that would satisfy the occurrences.

About 95% of claims made under insurance contracts in Ontario are settled without the necessity of the claimants engaging legal counsel. Of the remaining amount, many are settled prior to an actual trial, and only about 2% of all claims are decided by judicial determination of the appropriate court.

In Ontario, the Workers' Compensation Board, created under an act of the Ontario Legislature, handles all workers' claims against their employers. This is a distinct departure from the situation in the United States, where workers' compensation is a class of insurance sold by the private insurance industry. Its importance in Ontario is that professional drivers, who are entitled to receive workers' compensation benefits, are not entitled to claim for accident benefits under the standard automobile insurance contract. Further, their right of action against any wrongdoer is assumed by the Workers' Compensation Board, which claims on their behalf.

In addition, the Ontario Hospital Insurance Plan has a claim on behalf of any injured person who receives benefits under the Hospital Insurance Plan against a wrongdoer. In 1978, an agreement was arrived at between the automobile insurance industry and the Ministry of Health to avoid individual actions in each case, and to provide for bulk payment.

Certain features should be noted in connection with the provision of insurance to Ontario residents. These are:

1. Farm Mutuals

Over 85% per cent of farms in Ontario are insured by farm mutual insurance corporations. There are some 51 farm mutuals operating in Ontario, and many have been in existence over 100 years. They were created at a time when farmers had difficulty in obtaining insurance or paying for what insurance was available. These farm mutuals are owned by their policyholders and over the years have developed their own reinsurance plan. Their powers have been extended to provide automobile insurance, and they also provide environmental protection to their members.

2. Reciprocal Insurance Exchanges

Reciprocal insurance exchanges may be created under the Ontario Insurance Act. Such an exchange is an unincorporated group or pool of individuals or organizations that contract with each other to spread the risk and losses inherent in their activities.

If one member suffers a loss, the others contribute toward the payment of that loss, based on a pre-agreed formula. The members, usually called subscribers, traditionally cover any losses by paying some premiums up-front and agreeing to be assessed for the amounts in excess of that premium. The exchange is accordingly a form of mutual insurance that can be attractive to certain groups of organizations that have certain activities in common. It is limited to property and casualty insurance.

Very few such organizations ever existed in Ontario, probably because of the ready availability of reasonable insurance.

There is increased activity in the formation of such exchanges at the present time.

3. Pools

During the current crisis, groups of insurers have banded together to form pools, in order to provide coverage on difficult-to-place liability risks. The first such pool was created in November 1985 to provide coverage under the newly proclaimed Environmental Protection Act. It is known as the Spills Pool and has over 20 subscribing insurers. The pool has a rate manual, and all subscribing insurers join in the insuring agreement.

In January 1986, because of difficulties in placing certain liability coverages, an additional pool was created. Its initial users were day care centres and tavern keepers. The amount of coverage is limited to \$1 million. The pool is now known as the OLI Pool.

4. The Facility Association

The Facility Association came into being in 1980, with the advent of compulsory automobile insurance in Ontario. The principal purpose of the association is to guarantee market availability to any licensed driver in Ontario who could not obtain insurance through the ordinary market system. All licensed automobile insurers are members.

Insurance is placed through some 11 servicing carriers, who are licensed insurers. The rates charged for business placed are uniform. Coverages available are such as to ensure the availability of automobile insurance as required by law. In December 1985, the association, under special authority, undertook to permit limits for third-party liability of up to \$5 million U.S., in order to permit special filing requirements of the United States Inter-State Commerce Commission with respect to Canadian carriers.

The association is a non-profit organization, and its losses are borne by all licensed insurers.

The primary users of the Facility Association have been high-risk drivers. Where premiums collected from those insured are less than the cost of providing the insurance and claims, it can be stated that these insureds are receiving a subsidy. For liability coverage, the amount of this subsidy in 1984 was \$512.54.

5. Captives

Some of the larger businesses in Canada have created captive insurance companies. These arrangements for corporations and their affiliated companies permit the placing of insurance for corporate needs. Except for automobile insurance, which must be placed with licensed insurers, any person in Ontario is free to purchase insurance outside the province, for his own needs. The advantage to the insured is obvious, in that there is ability to structure a tailor-made insurance program and capacity that can be insured. Premiums remain a deductible expense in doing business. In several American states and in a number of off-shore countries, such as Bermuda, there is special legislation

which recognizes that certain insureds do not need the regulatory protection offered to the general public. In most instances, the usual insurance-type investment clauses are not applicable. An additional attraction is that the income earned on investments by the captive insurer may not attract tax in the domicile of the parent company.

Where captive insurers insure other third-parties, it is customary to do so by a reinsurance arrangement with a fronting, licensed insurer.

6. Self-Insurance

Many corporations retain the responsibility for their risks by establishing self-funded reserves. In such instances, corporations endeavour to retain the portion of the risk compatible with their own risk-bearing capacity. In short, they settle their own claims out of their own funds. In most instances, they provide for a form of excess insurance for losses sustained over a certain amount with a licensed insurer.

Insurance Industry Associations

As noted, the public in Ontario primarily deals with the insurance industry through agents and brokers. The majority of Ontario insurance brokers voluntarily belong to either the Insurance Brokers' Association of Ontario or the Toronto Insurance Conference. More than 1,250 brokerage firms are members of the two associations. Over 3,500 insurance brokers and support staff are employed by these firms.

With regard to insurers in the property and casualty insurance business, there is a history of special organizations - in the sense that bureaux were originally recognized and organized along provincial lines, with the purpose of designing suggested insurance contracts; settling rules, regulations and rates; and defining risks. The original organization was the Canadian Underwriters' Association. A number of independent conferences or bureaux also existed with respect to what were known as the non-tariff insurers, which were represented by the Independent Insurance Conference. In July 1974, the CUA and the IIC joined forces to form the Insurers' Advisory Bureau of Canada, which is now the principal advisory rating bureau in Canada.

The major insurers organization is the Insurance Bureau of Canada, which operates as an umbrella organization for most insurers in Ontario and Canada.

The Insurance Crime Prevention Bureau, as maintained by its member insurance companies, provides effective co-operation to police and fire authorities in the detection, investigation and prosecution of insurance crime.

Details of all three organizations are attached as an Addendum hereto.

Regulatory Framework and Principles

Legislative intervention by several provincial governments occurred before Confederation, in connection with the formation and affairs of mutual fire insurance companies, as well as to regulate fire insurance companies.

However, no specific mention of the subject of insurance appeared in the Constitution Act of 1867. As a result, there were numerous disputes between the federal and provincial authorities which were resolved in a series of judicial decisions ending in 1931. The latter years of this century have been characterized by regulatory co-operation.

In 1868, the federal Parliament began to legislate with respect to incorporation of individual companies, solvency and investment of insurance funds. As a result of the report of a Royal Commission, Ontario enacted legislation with respect to uniform conditions and policies of fire insurance in 1876.

In 1932, the federal Parliament passed the Canadian and British Insurance Companies Act, the Foreign Insurance Companies Act, and the Department of Insurance Act. These acts excluded previous federal provisions with respect to the condition of insurance contracts and concentrated on matters relating to the solvency of companies registered under the federal Acts.

In general terms, the federal government now concerns itself almost exclusively with the financial soundness of non-Canadian companies and of Canadian-incorporated companies which are registered federally. The provincial authorities concern themselves with their own incorporated insurers and all other insurance matters.

Insurance regulation by the governments of Canada may be categorized as promoting:

1. the financial solvency of insurers;
2. the viability of the insuring contract; and
3. the honesty and competence of insurance intermediaries.

All provinces and territories, as well as the federal government, have Superintendents of Insurance whose major focus has been the financial soundness of insurers. In addition to legislation and regulation, guidelines or directives are issued by the superintendents with respect to the conduct of the business of insurance.

A large degree of uniformity has been achieved in multiple licensing reporting and investment requirements. In general, the provinces rely on the supervision of the federal Department of Insurance over all federally registered insurers in connection with solvency.

The large degree of uniformity has been achieved, to a large part, by the Association of Superintendents of Insurance, now known as the Canadian Council of Superintendents of Insurance.

This association originated in a meeting in Western Canada by the four western provinces in 1914. Ontario entered in 1915, and in 1917 the association was organized. Quebec entered in 1921. New Brunswick, Nova Scotia and Prince Edward Island joined in the 1930s. Newfoundland joined in 1952, and the Northwest Territories and Yukon Territory joined in the 1970s. At the present time, the council has a permanent office in Ontario, and its administrative functions are performed by the Ontario superintendent's office.

The council continues the function of the Uniform Law Conference in relation to insurance matters and proposed uniform legislation. It is a forum for

discussion of common regulatory matters and co-operation between regulators. It has also issued standard guidelines to govern the conduct of the business in certain areas.

The council continues to meet twice yearly, once in April (an executive session) and once in the fall (a public session, where it invites submissions from the industry and the public). The council is not an administrative tribunal with rule-making authority over the industry. By reason of the fragmentation of the Property and Casualty Company and the number of companies operating, it is fundamental, however, that the companies be represented by strong industry associations.

History of the Development of the Structure of the Property and Casualty Insurance Industry - A Thumbnail Sketch

Many of the larger stock or mutual federally licensed insurers are active across Canada. The ten largest general primary insurers in Canada write business in all ten provinces and the territories. Seven of these insurers are among the ten largest writers of insurance in Ontario. Of the others, the Pilot Insurance Company writes only in Ontario and is provincially licensed, State Farm Insurance Companies are active in Ontario and in three other jurisdictions, and the Zurich Insurance Company writes business across Canada, but with over 60% of its business originating in Ontario. Both State Farm and Zurich are federally registered companies.

Three of the ten largest insurers in Ontario are direct writing companies; the remainder operate through the broker/agency distribution system.

The greatest contrast with Ontario is the structure in Quebec, where three of the four largest insurers are Quebec-based companies, each of which writes a preponderance of its business in that province. Together, they and other similar insurers are responsible for over 30% of all premiums written in that province.

Automobile Insurance. Automobile insurance is compulsory in all the provinces and territories. In Ontario, as well as in Newfoundland, Prince Edward Island, Nova Scotia, New Brunswick, Alberta, the Yukon, and the Northwest Territories, automobile insurance is the responsibility of private insurers.

In Quebec, bodily injury coverage is written through the Régie d'assurance and is the responsibility of the provincial government. Coverage is written on a no-fault basis, as is property damage liability insurance, which remains the responsibility of private insurers.

Three western provinces, British Columbia, Saskatchewan and Manitoba, have mandatory insurance through provincial government programs. Coverage provided under these programs is not available through the private sector. Optional coverages may be purchased through either government corporations or private insurers.

Other Insurance. In Manitoba, the Manitoba Public Insurance Corporation, and in Saskatchewan, the Saskatchewan Government Insurance, write other lines of insurance, in direct competition with the private sector. Both of these corporations are the largest single general insurers in their respective provinces.

In British Columbia, the general insurance business carried on by the Insurance Company of British Columbia was sold to a private carrier in 1984, and the provincial corporation is now restricted to automobile insurance.

Farm mutuals are provincially licensed in Ontario and operate basically in limited geographic areas of the province. Similar companies are also active in a number of other provinces.

Newfoundland and New Brunswick each have a number of small, provincially licensed companies which collectively, in the case of Newfoundland, write a significant percentage of the premiums generated within the province.

ADDENDUM - INDUSTRY ASSOCIATIONS

Insurance Bureau of Canada

The Insurance Bureau of Canada was formed in 1964 as the official voice of Canada's private sector property/casualty insurance companies. IBC is concerned with all classes of insurance except life, hail, accident and sickness, and ocean marine.

More than 100 insurance companies and groups, representing in excess of 80% of private industry insurance premiums, are provided, through membership in IBC, with programs and services.

One of the many functions of the Information Systems Division, located in Don Mills, is to receive and process the statistical information provided by every private sector company writing automobile insurance in Canada. Statistical exhibits (Green Book) are compiled semi-annually for publication and distribution to the Superintendents of Insurance and the insurance industry.

Premium and loss data, as defined in the Personal Lines and Commercial Lines Statistical Plans, are collected from member companies for annual production of the Brown Book and Red Book.

Judgment Recovery uses the information system for disposition of unsatisfied judgment claims. The system provides quarterly and annual assessments to insurers for the operation of the Unsatisfied Judgment Funds (Nova Scotia, Prince Edward Island and Newfoundland).

The Information Systems Division operates as a service bureau to the Facility Association and to the Groupement des assureurs automobiles (GAA). Semi-annual automobile accident year statistical exhibits are produced for the province of Quebec.

Facilities management services are provided to the Insurance Crime Prevention Bureau (ICPB), which provides to IBC-ICPB members information related to fraudulent or suspicious insurance losses, as well as automobile theft and salvage.

The Communications Division has responsibility for much of the two-way communication with IBC's many publics, both internal and external.

The division develops and implements a broad communications and advertising program designed to benefit the total general insurance industry and consumers of its services. This program has several objectives:

- to educate consumers to be informed buyers;
- to foster an appreciation of merits of the present private sector insurance system, including competitive pricing and service, and freedom of choice;
- to promote loss reduction and loss prevention;
- to monitor all aspects of the social, political and economic environment as they may affect the general insurance industry, to analyze this information, and to take appropriate action.

The Insurance Operations Division is made up of five distinct departments:

1. Actuarial and Statistical Services

The role of the Actuarial and Statistical Services Department is essentially four-fold:

- It controls the content of the IBC Statistical Plans for Personal Lines and Commercial Lines under which members report their statistics to IBC. It also is responsible for the implementation of all changes to the Superintendents' Statistical Plan for Automobile Insurance, under which all automobile insurers are required to report their statistics (outside of Quebec) to IBC.
- It contributes factors calculations to and reviews the major All Industry/All Member and Individual Company Statistical Exhibits (Green Book - Automobile; Brown Book - Personal Lines; Red Book - Commercial Lines) of the experience collected under the various statistical exhibits and may produce trial versions of new exhibits while they remain in the design stage.
- It is charged with the responsibility of seeing to it that controls are put into place to produce a reasonable level of quality both in the data submitted to and the statistical exhibits produced by IBC.
- It spends much of its time engaged in liaison. It works closely with the Data Centre Department with regard to Statistical Plan changes, problems with data submitted by companies, and exhibit production, and with the Development Centre Department with regard to systems and programming which support the transformation of raw data to statistical exhibits.

2. Claim and Field Services

This department is responsible for the administration of claims related services, as follows:

- Establishing a network of IBC-approved damage appraisal centres which are customer convenience, cost controlled and give a fair appraisal of damage.

A network of appraisal centres owned and operated by independent businessmen is in place in Newfoundland, Nova Scotia, New Brunswick, Ontario and Alberta.

Through reinspection of appraisals before, during and after repairs by both appraisal centre staff and IBC staff, the quality of appraisals is maintained throughout the network. IBC staff and appraisal centre staff are also directly involved in I-CAR (Inter-Industry Conference on Automobile Collision Repairs), effectively promoting training in and understanding of evolving automobile repair techniques.

Each appraisal centre utilizes the Audatex computer system to assist in the preparation of appraisals. Through pre-stored part numbers/prices and replace/refinish labour times, the accuracy of the appraisal is greatly enhanced, eliminating mathematical errors, overlaps/included operations and incorrect part prices.

IBC staff maintains close dialogue with Groupement des assureurs automobiles, which administers a network of appraisal centres in Quebec following similar policies and principles.

IBC is responsible for the co-ordination of the development of the Industry Claims Emergency Response Plan and for the administration of the plan in the event of an emergency.

3. Economic Research Department

- Contributes to the bureau's strategic planning and committee activity by providing inputs in the form of economic studies, market research and statistical interpretations.
- Coordinates the activities of the Financial Analysis Committee and its sub-committees, the Panel on Taxation, the Executive Data Processing Committee, the User Service Committee and the Directors' Ontario Advisory Committee.

It generates financial/accounting industry exhibits including the Expense Allocation and Reporting Program Results, Analysis of Profit and Loss of Canadian Business by Major Class, Provincial Allocation of Investments, and a quarterly analysis of Statistics Canada estimates of industry results. Monitoring of external trends includes the release of the Canadian Crash Parts Price Index, and interpretations of the quarterly Omnibus Public Opinion Survey.

4. Insurance Services Department

Provides full-time technical and administrative support to various committees where underwriting criteria, contract wordings, claim practices and consumers affairs can be studied and appropriate recommendations for improvements made. It is at the committee level that any basic changes to insurance contracts are first considered and, as desirable, implemented. Developments related to the prompt settlement of claims via inter-company agreements are usually initiated by the company representatives who make up the committees.

The work of the five product-line committees and the Claims Committee, composed of senior company executives, is co-ordinated by the Department:

- The Personal Lines Committee is responsible for the development and maintenance of the clear language habitation forms program. It administers and oversees the IBC Home Evaluation Program which provides members and policyholders with a system for estimating the cost of rebuilding a home.

- The Commercial Property Committee reviews and develops commercial property forms which are recommended for use to the member companies. One of its other major responsibilities is the management of the Property/Boiler Disputed Loss Agreement.
- The Liability Committee reviews and develops commercial liability forms which are promulgated for use by member companies. The committee monitors court awards and legislation covering subjects related to health and environmental concerns, responding to the needs of policyholders.
- The Automobile committee assists and advises Superintendents of Insurance on subjects such as automobile insurance legislation and forms. As well, the committee oversees studies of major importance to the industry such as the Automobile Classification Study.
- The National Surety Committee regularly reviews reports from its five regional committees to monitor changing market conditions and legislation across Canada. An important role of this committee is liaising with governments and industry associations to explain the role of suretyship and encourage the development of acceptable bond forms and practices. Through the efforts of its Claims Sub-Committee, a Surety Claims Code of Ethics was developed for the guidance of member surety writers.

The department is also responsible for co-ordinating the activities of the Claims Committee which reviews and approves forms and guidelines that make up the Agreement Respecting Standardization of Claims Forms and Practices. It is involved with the administration of the IBC Claims Emergency Response Plan, the Agreement of Guiding Principles with Respect to Overlapping Coverages Relating to Property Insurance and the Agreement of Guiding Principles Between Primary and Excess Liability Insurers Respecting Claims.

An important function of the department at Head Office is to provide a communication link through the Consumer Liaison Officer to enquiries from consumers on a wide range of topics related to policy coverages and claims settlements.

- Fire Underwriters Survey is a national organization financed by IBC. Through the Insurance Services Department, members are provided with data on the status of public fire protection in all areas of Canada for fire insurance classification purposes, developed by FUS.

Fire Underwriters Survey also assists municipalities in improving the ability of their fire departments to fight fires and better deal with fire protection and prevention problems.

5. Legal Division

The Legal Division maintains contacts with senior civil servants in the various provinces and territories and at the federal level. In particular, close contact is maintained with the Ministries of Justice, Consumer and Commercial Relations, Transportation and Communications, and Environment and, of course, with the various Superintendents of Insurance and Legislative Counsel. Through these contacts and through appearances before Select and Standing Committees of provincial legislatures and the federal Parliament, the Legal Division seeks those changes in the law which best serve the industry or lessen any adverse impact on the industry. Member companies are regularly informed by bulletin of changes in the law which may affect them in any way.

Members of the Legal Division regularly take part in the work of standing committees set up by the Association of Superintendents of Insurance of the Provinces of Canada and are frequently requested to respond to position papers by various public bodies such as Law Reform Commissions, etc.

The Legal Division keeps a very close watch on judicial interpretations of insurance contracts and takes to appeal those cases of general application where the court decision is not in accord with the spirit of the law or the intent of the contract. Where necessary, amendments to either the law or the contract are recommended to achieve the desired objectives.

In co-operation with the other Divisions of IBC, the Legal Division helps in the development, interpretation and revision of policy wordings; the drafting of industry agreements; and the preparation of responses to governments and other public bodies on all important issues.

With a staff complement of 140, the bureau maintains its head office in downtown Toronto and the Don Mills location, where the information systems, claims and field services, and actuarial and statistical functions are located, and has regional offices in the Atlantic Provinces, Quebec, the Prairies and on the West Coast.

Insurers' Advisory Organization of Canada

Insurer's Advisory Organization of Canada, formerly known as the Canadian Underwriters' Association, is a voluntary, non-profit organization funded by 52 groups of general insurance companies which underwrite more than 50% of the fire and casualty insurance business in Canada. Through its predecessors, the IAO can trace its history back to 1855 when the first association was established.

IAO supplies its members with technical services which can be broadly defined as:

Loss Prevention and Control - services which prevent or minimize loss, including fire protection, safety, security and loss control engineering; individual risk inspection; public fire protection surveys; and operation of a School of Loss Control Technology.

Risk Evaluation - services which develop the information needed by insurers to determine premium levels which reflect variations in the degree of risk or hazard.

IAO actuaries and rating staff develop statistical plans supplementary to the loss and expense statistical plans developed by the Insurance Bureau of Canada. The IAO plans contain the more detailed and refined data needed for ratemaking.

By analyzing and interpreting statistical exhibits and by applying actuarial and ratemaking techniques, IAO actuaries and rating staff develop advisory rate schedules for commercial property lines as well as advisory premium tables for habitational lines, personal and commercial automobile, crime coverages, general liability and employers' liability, glass, forgery, fidelity and surety (guarantee).

Where required, the IAO files its advisory rating programs with provincial regulatory authorities.

Services are provided by a staff of 500 people who are located in a network of 29 offices, stretching from coast to coast.

Insurance Crime Prevention Bureau

The Insurance Crime Prevention Bureau is a non-profit organization maintained by member insurance companies to provide effective co-operation to police and fire authorities in the detection, investigation and prosecution of insurance crime.

The bureau operates with the following branches:

- Fire Underwriters' Investigation Bureau;
- Canadian Automobile Theft Bureau; and
- Casualty Claims Index Bureau.

The main purpose of the Insurance Crime Prevention Bureau is to protect the public, insurance consumers and the insurance company from the ever-increasing cost of crime.

The bureau investigates:

- insurance crime, such as arson or faked burglaries, where the motive is fraudulent collection of insurance money; and
- insurance-related crime, motor vehicle theft and vandalism for example, where the motive varies but insurance loss is the result.

Operating throughout Canada, the Fire Underwriters' Investigation Bureau concentrates on crime associated with fire losses or fraudulent property insurance claims. With the continued infiltration of organized crime into legitimate business, these investigations have become extremely complex and are occupying much of the bureau's time and resources.

The Canadian Automobile Theft Bureau is fully operational in all provinces where private/independent insurers do business. CATB is concerned with criminal rings which steal motor vehicles for resale or for parts stripping, in

addition to investigating suspicious individual thefts and vehicle burnings where fraud may be involved.

The Casualty Claims Index Bureau records all bodily injury claims (whether automobile or other liability) and all accident benefit claims where the disability is known or predicted to be in excess of four weeks.

The bureau employs more than 70 special agents, each with at least eight years' policing experience prior to joining the staff. Special recruitment attention is given to candidates with extensive investigative background and experience in courtroom procedures.

APPENDIX 6

MANDATORY INSURANCE PROVISIONS - STATUTES OF ONTARIO

Ambulance Act

R.S.O. 1980, c.20

- paragraph 22(1)(b) (regulation-making authority)
- section 23 (offence provision)
- R.R.O. 1980, Reg.14, Part VII

Amusement Devices Act, 1986 (Royal Assent, January 17, 1986)

R.S.O. 1986, Bill 97, c.6

- section 4 (and regulations)

Architects Act, 1984

S.O. 1984, c.12

- paragraph 7(1)25 (regulation-making authority)
- paragraphs 8(1)24 and 25 (by-law-making authority)
- sections 39 and 40
- O.Reg.517/84, sections 35-40

Compulsory Automobile Insurance Act

R.S.O. 1980, c.33

- section 1 (definitions)
- section 2

Condominium Act

R.S.O. 1980, c.34

- subsections 27(1) and (5)
- section 49 (offence provision)

Education Act

R.S.O. 1980, c.129

- section 149.9

Grain Elevator Storage Act, 1983

S.O. 1983, c.40

- section 19
- section 25 (offence provision)

Local Services Board Act

R.S.O. 1980, c.252

- subsection 7(5)

Motorized Snow Vehicles Act

R.S.O. 1980, c.301

- section 11, as amended by S.O. 1982, c.13, subsection 4(3)

Off-Road Vehicles Act, 1983

S.O. 1983, c.53

- section 1 (definitions)
- section 15

Pesticides Act

R.S.O. 1980, c.376

- section 9
- section 37 (offence provision)
- R.R.O. 1980, Reg.751, section 19

Power Corporation Act

R.S.O. 1980, c.384

- section 1 (definitions)
- section 2 (application)
- section 97
- sections 101 and 103 (offence provisions)

(See also: **Power Corporation Insurance Act**,
R.S.O. 1980, c.385, which does not contain mandatory provisions)

Professional Engineers Act, 1984

S.O. 1984, c.13

- paragraphs 7(1) 24 and 26
- sections 35 and 36
- O.Reg. 538/84, section 38

Public Commercial Vehicles Act

R.S.O. 1980, c.407

- section 1 (definitions)
- section 28
- section 35, as amended by S.O. 1981, section 14 (offence provision)

Public Vehicles Act

R.S.O. 1980, c.425

- section 1 (definitions)
- section 27
- section 32 (offence provision)

MANDATORY INSURANCE PROVISIONS - REGULATIONS OF ONTARIO

Children's Residential Services Act

R.S.O. 1980, c.71

O.Reg.28/83

- section 21

Commodity Futures Act

R.S.O. 1980, c.78

R.R.O. 1980, Reg.114

- section 20

Conservation Authorities Act

R.S.O. 1980, c.85

R.R.O. 1980, Reg.125 (Catfish Creek)

- subsection 16(4)

R.R.O. 1980, Reg.127 (Credit Valley)

- subsection 19(5)

- paragraph 19(7)(a)

R.R.O. 1980, Reg.128 (Crowe Valley)

- subsection 21(3)

R.R.O. 1980, Reg.129 (Essex Region)

- subsection 21(3)

R.R.O. 1980, Reg.130 (Ganaraska Region)

- subsection 16(3)

R.R.O. 1980, Reg.131 (Grand River)

- subsection 16(4)

R.R.O. 1980, Reg.134 (Kettle Creek)

- subsection 16(4)

R.R.O. 1980, Reg.136 (Lower Thames Valley)

- subsection 15(5)

R.R.O. 1980, Reg.137 (Maitland Valley)

- subsection 16(4)

R.R.O. 1980, Reg.138 (Mattagami Valley)

-subsection 13(4)

R.R.O. 1980, Reg.140 (Napanee Region)

- subsection 16(3)

R.R.O. 1980, Reg.141 (Niagara Peninsula)

- subsection 16(4)

R.R.O. 1980, Reg.144 (Otonabee Region)

- subsection 21(3)

R.R.O. 1980, Reg.145 (Prince Edward Region)

- subsection 16(4)

R.R.O. 1980, Reg.146 (Rideau Valley)

- subsection 16(4)

R.R.OP. 1980, Reg.147 (St.Clair Region)

- subsection 16(3)

R.R.O. 1980, Reg.148 (Sauble Valley)

- subsection 16(4)

R.R.O. 1980, Reg.150 (Sault Ste. Marie Region)

- subsection 13(4)

R.R.O. 1980, Reg.151 (South Lake Simcoe)

- subsection 16(4)

Day Nurseries Act

R.S.O. 1980, c.111
 - O.Reg. 760/83, subsections 26(a) and (b)

Legal Aid Act

R.S.O. 1980, c.234
 R.R.O. 1980, Reg.575
 - section 36

Livestock Community Sales Act

R.S.O. 1980, c.247
 R.R.O. 1980, Reg.586
 - subsection 5(a)

Milk Act

R.S.O. 1980, c.266
 O.Reg. 442/81
 - subsection 27(a)

Niagara Parks Act

R.S.O. 1980, c.317
 R.R.O. 1980, Reg.686
 - paragraph 13(5)(d)
 - section 15

Petroleum Resources Act

R.S.O. 1980, c.377
 R.R.O. 1980, Reg.752
 - subsection 27(2),(3),(4)

Registered Insurance Brokers Act

R.S.O. 1980, c.444
 O.Reg. 637/81
 - section 21

Securities Act

R.S.O. 1980, c.466
 R.R.O. 1980, Reg.910
 - section 96

St. Clair Parkway Commission Act

R.S.O. 1980, c.485
 R.R.O. 1980, Reg.906
 - subsection 12(4)

St. Lawrence Parks Commission Act

R.S.O. 1980, c.486
 R.R.O. 1980, Reg.909
 - subsection 9(b)

MANDATORY INSURANCE PROVISIONS - STATUTES OF CANADA

Aeronautics Act

R.S.C. 1970, c.A-3

- paragraph 14(1)(j)
- section 16 (offence provision), as amended by S.C.1976-77, c.26, subsection 4(2)
- C.R.C. 1978, c.3, paragraph 20(1)(c)
- SOR/78-689 (adding 17.1)
- SOR/80-745 (amending section 17.1)
- SOR/81-953 (adding section 14.1)
- SOR/83-166 (amending paragraph 20(2)(a))
- SOR/83-443 (adding Part 11.1)
- SOR/84-903 (adding section 12.1)

Canada Grain Act

S.C. 1970-71-72, c.7

- subsections 36(1) and (2)
- paragraph 98(1)(k) (regulation-making provision)
- C.R.C. 1978, c.889, section 22

Canada Shipping Act

R.S.C. 1970, c.S-9, as amended by S.C. (2nd Supp.), c.27

- section 736 (which refers to sections 734 and 735)
- subsection 753(1) (offence provision)

Merchant Seamen Compensation Act

R.S.C. 1970, c.M-11

- section 29

Nuclear Liability Act

R.S.C. 1970, (1st Supp.), c.29

- sections 15 and 16

MANDATORY INSURANCE PROVISIONS - REGULATIONS OF CANADA

Arctic Waters Pollution Protection Act

R.S.C. 1970, c.2 (1st Supp.), as amended

Arctic Waters Pollution Prevention Regulations

C.R.C. 1978, c.354

- subsection 12(1)

Athletic Contests and Events Pools Act and Criminal Code

S.C. 1980-81-82-83, c.161 and R.S.C. 1970, c.C-34, respectively, as amended

Games Regulations

- S.O.R./84-350, May 1, 1984
 - section 2 (definitions)
 - subsection 14(1)

Sports Pool Systems Regulations

- S.O.R./84-326, April 19, 1984
 - section 2 (definitions)
 - subsection 14(1)

Criminal Code

- R.S.C. 1970, c.C-34, as amended

National Lottery Regulations

- C.R.C. 1978, c.431
 - subsection 15(1)
 S.O.R./78-681, August 24, 1978
 (which amended c.431, inter alia, by adding Part II re Lotto Select)
 - subsection 36(1)

Cooperative Credit Associations Act

- R.S.C. 1970, c.C-29, as amended

Protection of Securities (Cooperative Credit Associations) Regulations

- C.R.C. 1978, c.420
 - subsections 2(1) (definitions)
 - paragraphs 9(1)(a),(b),(c),(d)

Canadian and British Insurance Companies Act

- R.S.C. 1970, c.I-15, as amended

Protection of Securities (Insurance Companies) Regulations

- C.R.C. 1978, c.980
 - subsection 2(1) (definitions)
 - paragraphs 9(1)(a),(b),(c),(d)

Loan Companies Act

- R.S.C. 1970, c.L-2, as amended

Protection of Securities (Loan Companies) Regulations

- C.R.C. 1978, c.1031
 - subsection 2(1) (definitions)
 - paragraphs 9(1)(a),(b),(c),(d)

Trust Companies Act

R.S.C. 1970, c.T-16, as amended

Protection of Securities (Trust Companies) Regulations

C.R.C. 1978, c.1568

- subsections 2(1) (definitions)
- paragraphs 9(1)(a),(b),(c),(d)

St. Lawrence Seaway Authority Act

R.S.C. 1970, c.S-1, as amended

Seaway Regulations

C.R.C. 1978, c.1397, amended by S.O.R./80-256, April 8, 1980
- section 23

Livestock and Livestock Products Act

R.S.C. 1970, c.L-8, as amended

Stockyards Regulations

C.R.C. 1970, c.1025
- section 9

APPENDIX 7

TRENDS AND CYCLES, AVAILABILITY,
PRICE AFFORDABILITY, FINANCIAL PERFORMANCE

Prepared by
Coopers & Lybrand

APPENDIX 7

TRENDS AND CYCLES, AVAILABILITY, PRICE, AFFORDABILITY, FINANCIAL PERFORMANCE

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Introduction and Summary

This appendix presents a review and discussion of the following issues in the property-casualty industry in Canada, in general, and in Ontario, in particular: trends and cycles, availability, price, affordability, and financial performance. This discussion essentially summarizes the analysis and conclusions drawn from three studies undertaken by Coopers & Lybrand and another by the Wyatt company for the Task Force on Insurance.¹

The principal conclusions from the four broad sections of this Appendix can be summarized as follows:

Section 7.1

- There is sufficient current capacity in the property-casualty industry to meet any reasonable growth in general demand for insurance services for the foreseeable future.
- Capacity constraints or unavailability problems are localized to particular lines of business (primarily liability insurance) and, therefore, require specific and focused solutions.
- The property-casualty insurance industry in Ontario recently experienced the trough of its business cycle, characterized by capacity contractions and large price increases. Although the cyclical recovery is already underway, certain structural problems will persist, such as in liability insurance.
- Reinsurers have remained loyal in providing general capacity to the market. Capacity problems, however, are confined to particular areas.
- There has been a history of premium inadequacy in the property-casualty industry. Over the last six years, premium rates for a wide range of lines have averaged real declines of between 2.0 and 5.0 per cent, annually.

Section 7.2

- Personal insurance costs are minor budgetary items for the average family in Canada. Nevertheless, sharp increases in personal insurance premiums have stretched those on tight budgets.
- Liability insurance costs represent a negligible component of the total municipal tax base and the total provincial hospital operating budget in Ontario, respectively. Disruptions in their budgeting process were caused by unanticipated and large premium increases and unavailability of coverage for certain cases.

Section 7.3

- Return on investment is volatile and has generally been below returns achieved by other industries.

¹ The three papers undertaken by Coopers & Lybrand for the Task Force on Insurance are titled: "Review of Trends and Cycles in Availability and Price of General Insurance Services"; "The Financial Performance of the Property-Casualty Industry"; and "Summary Paper: Causes and Prospects for the Current Cycles in Availability and Price, Financial Performance and Reserve Experience in the General Insurance Industry". The paper by The Wyatt Company is titled "An Overview of Methods and Estimates of Claim Reserve Liabilities for the Property-Casualty Industry".

- The investment returns achieved by the Ontario insurers are consistently below the rate of return achieved by investing in Canadian mid-term corporate bonds.
- There is a marked deterioration in the liability direct loss ratio from 1981 to 1984.
- The automobile direct loss ratio has deteriorated significantly since 1982.
- Expenses of Ontario insurers as a percentage of earned premiums are higher than the United States and provincial government insurers.
- Insurers are dependent on investment income to offset underwriting losses and earn a profit. There has not been an underwriting profit during the period 1978 to 1984.
- The high level of retention of profits has provided the solvency and financial backing for the industry over the last decade.
- The industry is generally solvent and liquid; solvency would appear to have improved since 1981.
- Claims reserves represent a significant portion of an insurance company's financial structure and have experienced a marked increase during 1984 that was centred on commercial liability reserves.
- Claims reserves stated on the 1984 financial statements were approximately \$956 million deficient (18.7 per cent of stated reserves) on a non-discounted basis.
- The most prevalent cause for insurance company failure is the relationship of an insurer with related companies, either by way of management agency contracts or reinsurance, resulting in liquidity problems.
- The Canadian reinsurance industry is solvent and profitable; however, certain deviations from this norm may occur in specific business lines within individual companies.

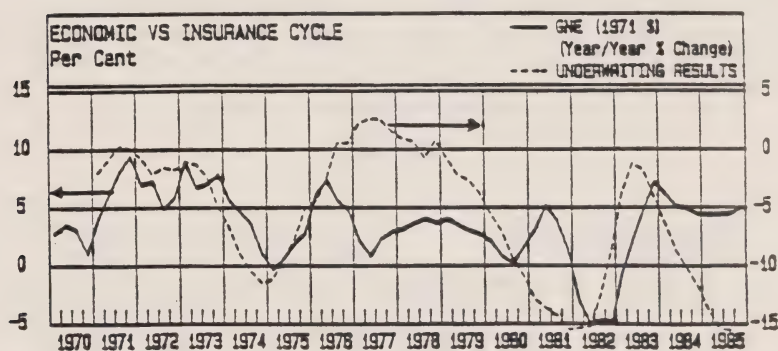
Section 7.4

- Large claims do not appear to be, in themselves, a reason for rapid increases in overall automobile-related claims.
- Whereas the frequency of claims has largely declined over the period 1981-1985, the average cost per claim has risen substantially and is the critical factor underlying overall automobile claims growth in Ontario.
- The fairly stable relationship observed between general expenses and net earned premiums over the period 1978-1984 suggests a stagnant productivity situation.
- Insurers pay a high proportion of total revenue as commission to agents on acquisition of premiums.
- There has been a marked rise in reinsurance costs in most lines and substantial increases in certain lines where residual reinsurance is still offered.
- There appears to be little further capacity in foreign markets for liability risks, particularly emanating from North America.
- The competitive structure of the industry and the peculiarity of its distribution system explain the excessively competitive pricing policies and the lags in response evident in the price-cost-performance relationship.
- The recent cyclical downturn in the property-casualty industry was exaggerated by a series of shocks that have impeded the inherent self-corrective mechanisms in the industry that usually work towards alleviating cyclical problems.

7.1 A Description and Analytical Review of Trends and Cycles in Availability and Prices of Various General Insurance Services.

The business cycle experience measured by changes in real Gross National Expenditure (GNE) on a national basis does not convey the wide divergence in the cyclical experience of particular sectors and the provinces. The property-casualty insurance industry in Canada and in Ontario, in particular, does experience, as do most other industries, cyclical fluctuations in performance.

CHART 1



Source: Statistics Canada, Financial Institutions, Cat. No. 61-006 and National Income and Expenditure Accounts, Cat. No. 13-001.

However, these cycles (measured by underwriting results which are defined as the underwriting gain/loss as a percentage of earned premiums) have not conformed closely with the economic cycles observed and, in recent times, the magnitude of the downcycle has been particularly pronounced and prolonged. Furthermore, while the benefits of the economic recovery since the end of 1982 have spread to some degree into most industries, there is little evidence of such a development taking hold in the property-casualty industry. In fact, the underwriting experience and income performance has steadily deteriorated over the last three years.

Clearly, a set of external and internal forces are at play that serve to exaggerate the frequency and amplitude of the "normal" business cycle observed in the property-casualty industry. There appears to be a growing dissonance between the dynamics in the industry and macro-economic developments that have led to an accentuated downturn in the industry in Canada. Also contributing to the recent unfavourable trends is the general downtrend in world insurance markets and emerging capacity constraints in certain segments of international reinsurance markets.

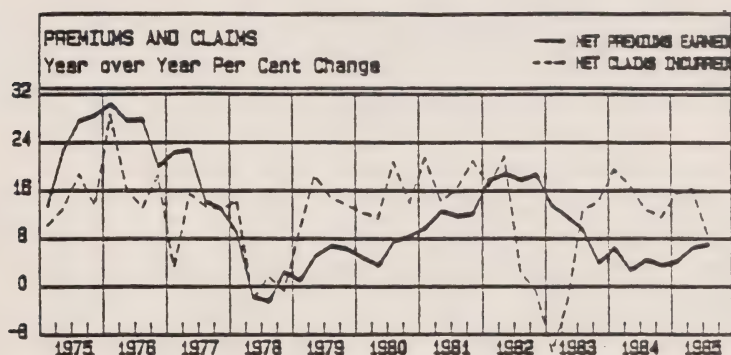
The severe downcycle the industry has experienced has aggravated and focused public attention on some critical structural issues. The normal

innovative experience of the industry and the inherent self-corrective mechanisms in the market have been hindered by the severity of the downturn in dealing effectively with these issues. Furthermore, the normal ability of the cyclical upswing to alleviate structural problems is now uncertain as some significant changes to market structure and institutions have now surfaced. It is our understanding that although cyclical issues will ease, structural problems will persist in the following areas: liability insurance; environmental pollution insurance; product liability insurance; professional liability insurance; and coverage for the voluntary sector.

Premiums and Claims Experience in Canada

One of the principal reasons the industry finds itself in its current problems is that premium growth has not been sufficient to cover the rapid increases in claims incurred. Over the period 1975 to the third quarter, 1985, net premiums earned averaged a compound growth rate of 10.7 per cent to a level of \$3.3 billion. In contrast, net claims incurred averaged a compound growth rate of 11.7 per cent to a current level of \$6.4 billion.

CHART 2



Source: Statistics Canada, Financial Institutions, Cat. No. 61-006.

During the last ten-year period, however, premiums and claims experienced two complete business cycles. In fact, the third business cycle has been underway since the early part of 1985. During 1984, claims increased by 15.2 per cent while premiums expanded by only 4.1 per cent, thereby lending a sense of urgency to the current situation. The first quarter of 1985 saw premium growth pick up smartly whereas claims growth during the third quarter of 1985 started to converge with that of premiums for the first time during the previous eight quarters. The continuation of these trends will contribute, in part, to the alleviation of the current state in the insurance industry.

Capital Utilization and Excess Capacity

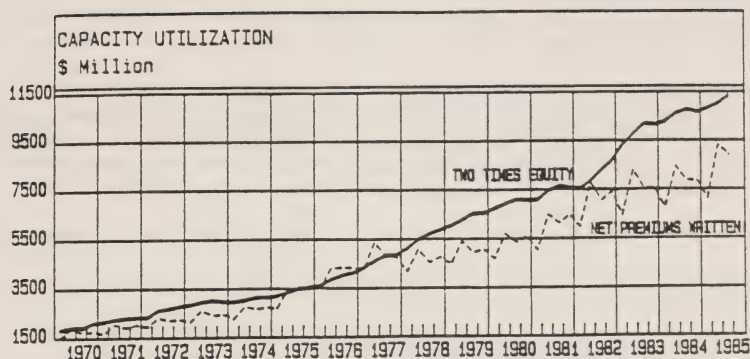
The concept of capacity in the general insurance industry is nebulous, reflecting more an attitude adopted by insurers rather than physical or purely financial capability. In essence, capacity in the industry is the supply of willingness to assume risks, which is determined by the following factors:

- o the equity (capital and surplus) position of the industry;
- o the relationship between the actual claims experience and expected value of claims based on developments in the frequency and size of settlements;
- o actual investment income relative to expected earnings;
- o the level of expenses incurred relative to that anticipated; and
- o the risk assessment in particular lines of business, which is determined not only by the claims experience but by broad environmental and judicial (settlement awards) developments.

Thus, a review of cycles and trends in capacity, on an industry-aggregate basis and on a specific line-of-coverage basis, lends itself better to a qualitative rather than a quantitative assessment. Nevertheless, we will review developments in the equity position of the industry and draw conclusions about the general financial capacity to assume risks. Data limitations preclude an extension of the analysis on a specific business line basis.

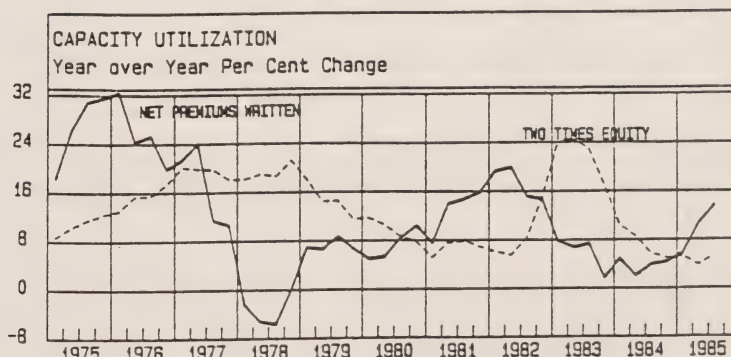
To illustrate the degree of capacity in the industry we use two alternative measures: conservative and expanded. The conservative measure defines capacity (used in the charts below) as two times equity and is a measure adopted by the IAO (Insurers' Advisory Organization) that has found wide acceptance. An expanded measure of capacity providing for more efficient use of capital might be as high as 2.75 times equity. This still remains below the critical level of three times equity which the regulators use to judge a company's ability to expand its premium base.

The Canadian property-casualty insurance industry is conservatively leveraged and has had, on average, a consistent measure of excess capacity except during the "crunch period" of 1976/77. This is illustrated in the chart below which compares capacity (defined as two times equity) and utilization in the sense of net premiums written. Capacity utilization has fallen to record lows in recent years.

CHART 3

Source: Statistics Canada, Financial Institutions, Cat. No. 61-006.

Although the current excess capacity situation is rather bleak, the future outlook is buoyed by a turnaround to higher utilization rates in early 1985. As the accompanying chart illustrates, growth in premiums began to outstrip the gradually dampened expansion in capacity during 1985. However, it will require sizeable increases in premiums accompanied by static capacity to remedy the excess capacity within a reasonable time frame.

CHART 4

Source: Calculated from the data in Chart 3.

By the conservative measure, excess capacity during the third quarter of 1985 was \$2.4 billion or 21.2 per cent of capacity. This represents a

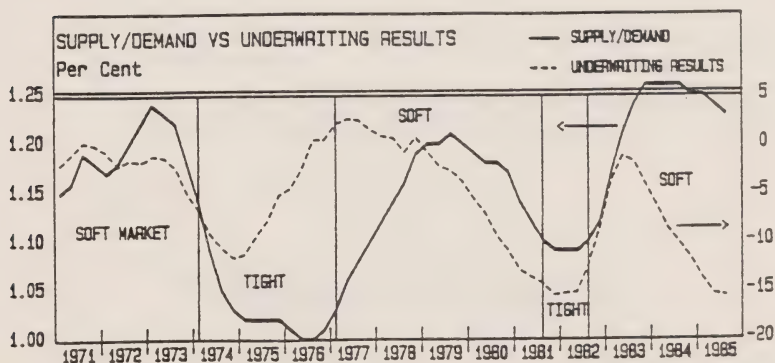
measurable reduction from the peak excess level of \$2.8 billion (26.3 per cent of capacity) achieved during 1984. The patterns are identical with the expanded measure of capacity. On this basis, excess capacity during the third quarter of 1985 was \$6.6 billion, or a very high 42.7 per cent of capacity.

This analysis suggests that there is sufficient current capacity in general demand for insurance services for the foreseeable future. Capacity constraints or unavailability problems are obviously localized to particular lines of business and, therefore, require specific and focused solutions.

Implications of the Capacity Cycle

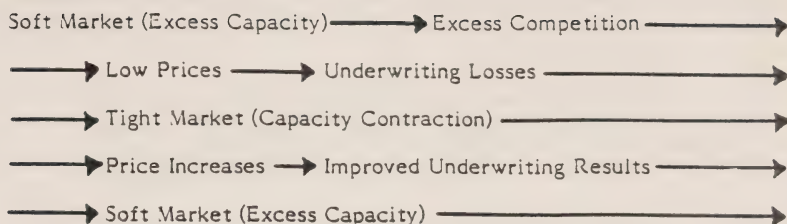
Our analysis further confirms the notion that the industry is largely supply driven. It is the ebb and flow of excess capacity in the industry that determines the pricing cycle and ultimately, the underwriting results. Over the last decade-and-a-half, the industry has experienced two-and-a-half capacity cycles with predictable results on underwriting performance.

CHART 5



Source: Statistics Canada, Financial Institutions, Cat. No. 61-006 and National Income and Expenditure Accounts, Cat. No. 13-201; and Insurers' Advisory Organization.

The above chart utilizes the IAO's supply/demand monitor concept to illustrate the capacity cycle and the various episodes of soft and tight insurance markets. The supply/demand monitor is defined as equity as a share of Gross National Product and provides a graphic illustration of excess supply and excess demand periods. A surprisingly tight correlation is observed between the supply/demand condition and underwriting results (underwriting gain/loss as a per cent of earned premiums). The causal relationship that is operative in the industry is as follows:



The capacity cycle would lead us to believe that the recent situation of severe underwriting losses was a result of heightened price competition brought on by excess capacity. The current capacity contractions and large price increases are predictable elements of this scenario.

The Reinsurance Cycle

The reinsurance market experiences the same wrenching adjustments on price and capacity as the primary market due to several factors:

- o incomplete information on risks being underwritten by the primary insurers;
- o high loss ratios due to claims growth and associated uncertainties regarding long-tail liabilities in certain lines;
- o a history of premium rate inadequacy.

TABLE 1

Canadian Premiums in Non-Life Business
(Direct Insurance and Reinsurance)

<u>Year</u>	<u>Direct¹</u> <u>Insurance</u>	<u>Period-to-</u> <u>Period %</u> <u>Change</u>	<u>Reinsurance²</u>	<u>Period-to-</u> <u>Period %</u> <u>Change</u>	<u>Reinsurance</u> <u>as a % of</u> <u>Direct</u>
1979	4,970	7.0	538	26.9	10.8
1980	5,328	7.2	642	19.3	12.0
1981	6,028	13.1	818	27.4	13.6
1982	7,056	17.1	961	17.5	13.6
1983	7,456	5.7	1,098	14.3	14.7
1984	7,724	3.6	1,107	0.8	14.3

¹ Net premiums written by Property-Casualty Primary Insurers.
Source: Statistics Canada, Financial Institutions, Cat. No. 61-006.

² Gross premiums assumed by reinsurers.
Source: Canadian Insurance/Agent & Broker, Annual Statistics (1980-1985)

Several developments in Canadian direct and reinsurance markets become apparent in the above table:

- o The insurance downcycle in Canada has lagged that in world markets, particularly Western European markets. Direct insurance premium growth was strong during 1980 to 1982 and only experienced a slowdown in 1984.
- o Reinsurance premiums underwent rapid growth over the period 1979 to 1983. This expansion is, in part, attributed to the aggressive marketing efforts of unregistered insurers.
- o The contraction in Canadian reinsurance markets was recorded initially during 1984. This lags comparable developments in the United States' market by at least a year and that in world markets by two to three years. Similarly, reinsurance premiums also lagged the slowdown in the domestic direct insurance markets.
- o Reinsurance increased sharply by almost four percentage points as a share of direct insurance premiums over the period 1979 to 1983 to a peak of 14.7 per cent. While this ratio is below the world average, it is almost twice that of the United States. This provides partial evidence of the increased reliance of domestic insurers on ceding reinsurance and reducing the retention of the business written on their own accounts. However, the increased reinsurance ratio is by no means excessive yet.

In summary, the reinsurance "crunch" did not take place in Canada until well into 1984 and 1985. This is a year to several years behind similar developments elsewhere in world markets. The withdrawing of unregistered reinsurers and "naive" reinsurers after several years of pronounced adverse experiences was a key factor. The abuse of easily available reinsurance during the good years led to inadequately low retention rates by many primary insurers. As a result, underwriting risks were disproportionately transferred to reinsurers with ultimately negative results.

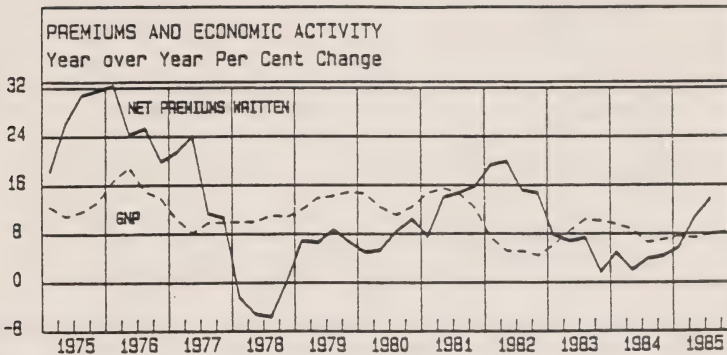
The Pricing Cycle

The conventional case is where the demand of a product is strongly related to the level of economic activity or income. The price of the product is then largely determined by excess demand conditions in the market. Property-casualty insurance services are distinctly unconventional products. The accompanying chart illustrates that the growth in premiums is surprisingly uncorrelated with changes in economic activity. Demand conditions, therefore, do not play a critical role in the market for general insurance.

The key determinant to premium growth is prices. As we have already discussed in the section on the capacity cycle, prices of general insurance services are largely supply driven. It is the ebb and flow of excess-supply conditions in the market that determines the pricing cycle.

In summary, excess-capacity and pricing are the key factors that determine the internal dynamics of the property-casualty industry in Canada.

CHART 6



Source: Statistics Canada, Financial Institutions, Cat. No. 61-006 and National Income and Expenditure Accounts, Cat. No. 13-201; and Insurers' Advisory Organization.

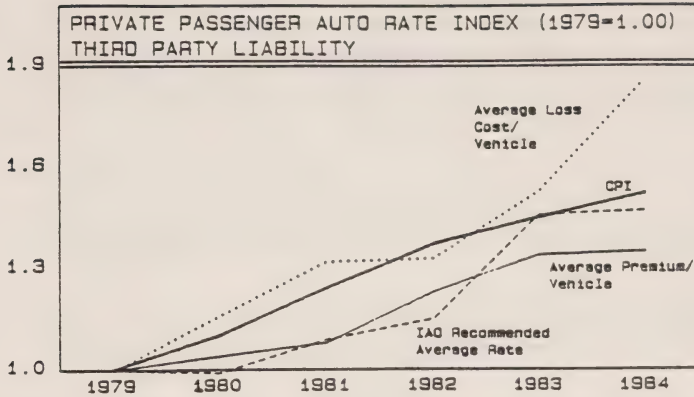
a) Private and Commercial Automobile Rates

The Insurers' Advisory Organization (IAO) has an extensive data base that summarizes rates and claims costs for various classes of coverage for private passengers and commercial automobiles. Our analysis of a representative sample of these rates portrays a picture of the premium rate inadequacy that is a key factor in the current problems.

The salient features of the experience of the private passenger automobile rates over the period 1979 to 1984 are:

- o Average premiums for third-party liability lagged increases in the Consumer Price Index (CPI), the IAO recommended rate and claim losses (see Chart 7).
- o In real terms, the average premium for third-party liability experienced a cumulative decline of 11.2 per cent over the six years.
- o Average premiums for collision and comprehensive coverage were more than adequate for losses and generally followed IAO recommended rates.

CHART 7

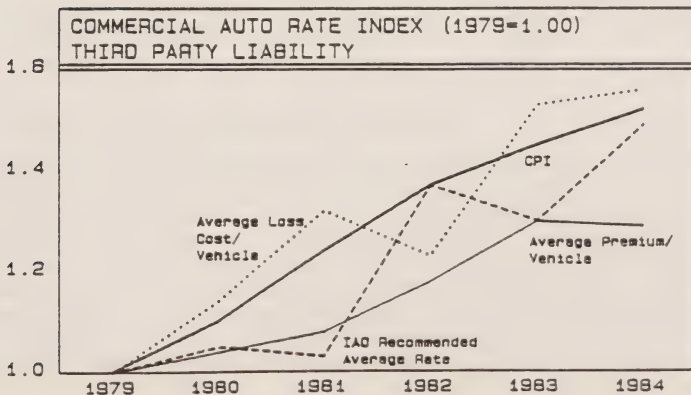


Source: Insurers' Advisory Organization of Canada and Statistics Canada. Consumer Prices and Price Indexes, Cat. No. 62-010.

The experience of commercial automobile rates is broadly similar to that of private passenger automobiles and are summarized below:

- o Average premiums for third-party liability lagged by a wide margin increases in the CPI and IAO recommended rates and claims costs (see Chart 8).
- o In real terms, the average premium for third party liability incurred a cumulative decline of 15.1 per cent over the six years.
- o The premium rate experience for collision and comprehensive coverage was much more than adequate to cover losses but was below IAO recommended rates.

CHART 8



Source: Insurers' Advisory Organization of Canada and Statistics Canada. Consumer Prices and Price Indexes, Cat. No. 62-010.

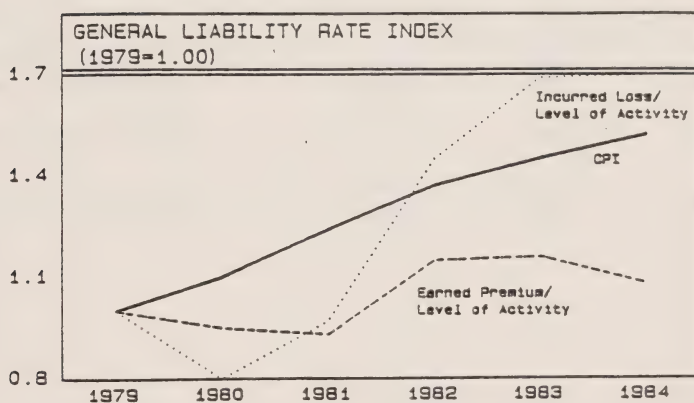
b) General Liability Rates

Liability insurance lines cover such a wide and heterogeneous variety of risks that it is difficult to summarize the general experience. In fact, the IAO contends that the statistics in the liability lines are not sufficiently complete in order to provide proper direction and recommendations on risk classifications and rates. A representative general liability rate index (with all the caveats) for Canada was, however, constructed.

The experience would suggest:

- o Earned premiums are significantly inadequate to cover losses and have lagged increases in the CPI by a substantial margin (see Chart 9).
- o In real terms, earned premiums have experienced a cumulative decline of 28.9 per cent over the six-year period reflecting the injurious competitive pricing practices.

CHART 9



Source: Insurers' Advisory Organization of Canada and Statistics Canada. Consumer Prices and Price Indexes, Cat. No. 62-010.

7.2 Affordability of General Insurance Services

An analysis of average family expenditures in Canada indicates that personal insurance costs are minor budgetary items (see Table 2). During 1982, personal insurance payments made to the property-casualty industry (tenants' insurance premiums, homeowner's insurance premiums, and vehicle insurance premiums) accounted for only 2.0 per cent of the family expenditure budget. Other insurance related expenditures include: health insurance premiums (private and public), 0.7 per cent; life insurance premiums (including group insurance premiums), 0.8 per cent; unemployment insurance, 0.9 per cent; and retirement income maintenance, 2.5 per cent.

TABLE 2
Average Expenditure in Canada, 1978 and 1982
All Families and Unattached Individuals

	Dollars		Per Cent of Total Expenditure	
	1978	1982	1978	1982
Food	3,188.5	4,131.1	16.8	15.3
Shelter	3,060.7	4,742.0	16.1	17.5
Tenants' insurance premiums	3.0	22.0	0.0	0.1
Premiums for insurance on home	65.4	146.2	0.3	0.5
Household Operation	782.0	1,177.1	4.1	4.3
Household Furnishings and Equipment	368.4	972.0	4.6	3.6
Clothing	1,298.7	1,650.6	6.8	6.1
Personal Care	312.6	490.8	1.6	1.8
Medical and Health Care	368.1	522.2	1.9	1.9
Health insurance premiums	142.4	190.0	0.7	0.7
Tobacco and Alcoholic Beverages	613.6	392.2	3.2	3.3
Transportation	2,425.6	3,270.6	12.7	12.1
Vehicle insurance premiums	241.8	382.3	1.3	1.4
Recreation	947.7	1,261.4	5.0	4.7
Reading	103.1	157.9	0.6	0.6
Education	121.3	183.3	0.6	0.7
Miscellaneous	461.9	796.5	2.4	2.9
Total Current Consumption	14,557.2	20,252.8	76.5	74.8
Personal Taxes, Security and Gifts	4,476.6	6,809.4	23.5	25.2
Life insurance premiums	175.5	220.0	0.9	0.8
including group				
Annuity contracts	27.5	38.1	0.1	0.1
Unemployment insurance payments	163.8	254.0	0.9	0.9
Retirement and Pension Fund payments	425.4	649.7	2.2	2.4
TOTAL EXPENDITURE	19,033.7	27,062.3	100.0	100.0

Note: Details may not add due to rounding.

Source: Statistics Canada, Family Expenditure in Canada, Cat. No. 62-551 and 62-555, Occasional Percentage Calculations by the Economics Practice, The Coopers & Lybrand Consulting Group.

Although a relatively minor budgetary expenditure, sharp increases in personal insurance premiums have stretched those on tight budgets and created uncertainties in the budgeting process. A similar conclusion can be drawn for municipalities and hospitals which are faced with large premium increases. The exception in these situations is the unavailability of coverage in certain cases and the consequent resorting to reciprocal insurance arrangements.

The evidence presented in Table 3 suggests that municipal liability insurance premiums were a negligible component of the total municipal tax base in Ontario over the period 1981-1984. In fact, an estimate of municipal liability costs averaged only 0.05 per cent of total municipal revenues in Ontario over the four-year period. Although liability insurance premiums have had some large increases during 1985 and into 1986, they are still estimated to account for only 0.1 per cent of municipal revenues. The incidence of unanticipated large premium increases falling on smaller municipalities has caused considerable hardship.

Data from the Ontario Nurses' Association and the Canadian Medical Protective Association indicates a similar pattern of affordability and price increases to that for families and municipalities outlined above. Hospital liability insurance premiums have risen from an estimated \$3.5 million in 1983-1984 or 0.09 per cent of the hospital operating budget to \$20.5 million during 1985-1986 or 0.49 per cent. Expected increases for 1986-1987 will result in premiums about \$41 million or 0.95 per cent of the total provincial hospital operating budget.

TABLE 3
Municipal Liability Insurance Costs as a Share
of the Municipal Tax Base: Ontario
(Millions of Dollars)

	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>
Estimate of Municipal Liability Costs (A)	6.2	5.1	5.3	6.2
Municipal Revenues (B)	10,065	11,161	12,205	13,123
A as a percentage of B	.06	.05	.04	.05

Sources: A - Frank Cowan Company Ltd., a brokerage firm insuring 70 per cent of municipalities in Ontario. These figures were extrapolated to reflect costs of all municipalities.

B - Statistics Canada, Provincial Economic Accounts, Experimental Data (1969-84), Cat. 13-213 Annual.

7.3 Financial Performance of Different Parts of the Industry

Unlike the life insurance industry, the property-casualty insurance industry has, for the most part, reported its results in accordance with generally accepted accounting principles, rendering the results comparable to other

industries. This situation has existed for at least the past five years for federally incorporated insurers and federally registered Canadian branches of foreign insurers; these form the largest section of the industry. The results reported by provincially incorporated insurers might not conform with generally accepted accounting principles in some minor respects, but over the years these results should also be comparable to generally accepted results.

In addition, with the exception of federally registered Canadian branches of foreign insurers, the annual results of all Canadian insurers have been reported on by external auditors; the home offices of foreign companies generally require that the results of their Canadian branches be subjected to independent audit. Further, the loss of provisions of many of these insurers have been subjected to additional certification, often by fully qualified actuaries. Finally, examinations are routinely carried out by the examination staff of the federal and provincial Departments of Insurance for those insurers under their jurisdiction. This examination and audit process renders the property-casualty insurance industry one of the most heavily examined in Canada.

This section documents the financial performance of the property-casualty insurance industry using key industry-accepted indicators to provide a framework to examine the financial health, viability and structure of the industry. Also, an attempt has been made to compare the total Canadian and Ontario industries, although little pure Ontario data is available. This analysis focuses on the property-casualty insurance industry trends in general; such trends may not hold true for all companies and sub-groups within the industry.

Total Revenue Dollar

Based on total Canada operating results for 1984, the following table illustrates how a revenue dollar is expended:

TABLE 4
Composition of Total Revenue Dollar: 1984
(Per Cent of Total)

	<u>Revenue</u>	<u>How Revenue is Expended</u>	
Investment Income	15	4	Profit before Income Tax
		3	Premium Taxes
Earned Premium	35	12	General Expenses
		13	Commissions
		<u>68</u>	Claims and Adjustment Costs
	<u>100</u>	<u>100</u>	

Source: Annual Reports of the Superintendent of Insurance, Federal and the Province of Ontario, 1984.

Review of the table indicates:

- (i) The relative significance of investment income on the insurer's ability to earn profit.
- (ii) The proportion of revenue paid as commission to agents on acquisition of premiums.

Return on Investment ("ROI")

Return on investment expresses net income after tax as a percentage of average shareholders' equity during a period. It is an indicator of the profitability of an insurer and is used to compare different companies or industries.

TABLE 5

Comparative Return on Investments
(Per Cent)

	<u>Average</u>	<u>1984</u>	<u>1983</u>	<u>1982</u>	<u>1981</u>	<u>1980</u>	<u>1979</u>
Ontario Insurers	8.8	7.6	14.9	11.1	(1.1)	7.7	12.4
Total Canadian	9.3	6.8	15.7	11.1	3.2	6.3	12.5
Banks (*1)	15.9	13.1	15.6	14.4	18.6	16.8	16.7
Trust, Savings and Loan (*1)	13.9	14.5	13.9	14.1	11.9	14.7	14.3
Utilities (*2)	12.4	13.5	11.1	9.9	12.1	13.2	14.4
Merchandising (*2)	12.2	10.6	10.9	11.2	12.5	13.6	14.3
Oil and Gas (*2)	13.0	9.7	7.5	6.8	12.9	21.7	19.6
Canadian Mid-Term Corporate Bond Yield (*3 and *4)	9.0	8.7	8.0	10.4	10.9	8.9	7.3

Source: Annual Reports of The Superintendent of Insurance, Federal and the Province of Ontario.

*1 Source: Annual financial statements of certain banks, trust, savings and loan companies.

*2 Source: Certain major companies from Financial Post Survey of Industrials

*3 Source: Bank of Canada Review.

*4 Adjusted to an after-tax basis using 33-1/3 per cent tax rate.

() represents a negative return.

In the absence of pure Ontario statistical information, we have defined "Ontario" companies as those which in 1984 had 55 per cent or more of their direct written premiums in Ontario. These "Ontario" companies total 45 and account for 40 per cent of the premiums written in the province. Of the total premiums written by these "Ontario" companies, only 25 per cent relate to premiums written outside of Ontario.

Included in our definition of "Total Canada" are all federally registered property-casualty insurance companies, excluding the Mortgage Insurance Company of Canada. This includes Canadian, foreign and British companies. Excluded from our definition of "Total Canada" are provincial government insurers and all other provincially registered companies.

The results from the table indicate:

- (i) Over the last six years the Ontario insurers have realized returns that are generally comparable to, but slightly lower than, the returns earned by Canadian insurers.
- (ii) With the exception of 1983, insurers in both Ontario and total Canada have been achieving a consistently lower ROI than other financial institutions such as banks and trust, savings and loan companies.
- (iii) That the insurance industry has encountered volatile results and has not consistently out-performed other major industrial sectors.

Early statistics for property-casualty insurers Canada-wide indicate a return on investment for 1985 of 6.9 per cent, which is similar to the rate achieved in 1984 (Source: The Quarterly Report, Volume IV, Number 4, Insurers' Advisory Organization of Canada).

Underwriting Performance of Property-Casualty Insurers

(a) Loss Ratio

The loss ratio expresses claims and claim adjustment expenses as a percentage of net earned premiums.

TABLE 6
Loss Ratio of Property-Casualty Insurers
(Per Cent)

	<u>1984</u>	<u>1983</u>	<u>1982</u>	<u>1981</u>	<u>1980</u>	<u>1979</u>	<u>1978</u>
Ontario Insurers	80.5	73.5	76.6	82.9	75.7	71.3	67.5
Total Canada	78.4	70.9	74.8	81.2	75.3	69.9	64.5
U.S. average (*1)	88.1	81.4	79.7	76.7	74.9	71.6	69.0
Provincial Government Insurers	93.2	93.5	96.4	97.5	106.8	95.0	86.3

*1 Source: 1980 to 1984: Best's Review, Property and Casualty Insurance Edition, January 1986 and May 1985. 1979 and 1978 SIGMA/Swiss Re 9/85 and 9/84.

Source: Annual Reports of The Superintendent of Insurance, Federal and the Province of Ontario; Annual Statements of Provincial Government Insurers.

The table indicates that the Ontario insurers have consistently experienced losses in excess of the Canadian average, but have performed better than the United States property-casualty insurers in the years 1982 to 1984.

Results for 1985 are not yet available for Ontario insurers; however, preliminary figures for 1985 as a whole indicate that Canada has continued to experience a loss ratio deterioration to 82.5 per cent, even though this ratio is still lower than that experienced in the United States (based on the loss ratio estimate reported by Best's Review, January 1986).

Direct Loss Ratio - By Line

Statistics were not available to indicate a loss ratio, on a line by line basis. However, the direct loss ratio, which expresses direct claims and claims adjustment expenses as a percentage of direct premiums written, is indicated below for major lines.

TABLE 7
Direct Loss Ratio of Property-Casualty Insurers - By Line
(Per Cent)

	<u>1984</u>	<u>1983</u>	<u>1982</u>	<u>1981</u>	<u>1980</u>	<u>1979</u>	<u>1978</u>
<u>Automobile</u>							
Ontario (*1)	97	35	30	37	32	77	75
Other Provinces	72	62	67	33	32	75	71
<u>Liability</u>							
Ontario (*1)	90	105	35	63	43	39	67
Other Provinces	95	94	72	63	55	61	73
<u>Property</u>							
Ontario (*1)	63	52	65	68	64	61	51
Other Provinces	65	60	68	76	71	61	52
<u>All Lines</u>							
Ontario (*1)	84	75	75	78	71	68	65
Other Provinces	73	66	68	76	73	66	61

*1 Ontario statistics are as reported on INS 52 and 53 annual statements submitted to the Department of Insurance and are not our definition of "Ontario".

Source: Annual Report of The Federal Superintendent of Insurance.

The data contained in the above table indicates:

- (i) The liability line is highly volatile, with marked deterioration in 1983 and 1984. This is confirmed by statistics for total Canada on an earned/incurred basis, which show loss ratios for 1983 at 100 per cent, 1984 at 103 per cent and 1985 at 98 per cent. (Source: Insurers' Advisory Organization).
- (ii) The automobile direct loss ratio for Ontario has significantly deteriorated since 1982.

- (iii) Property insurance has a relatively stable nature.
- (iv) For all lines, with the exception of 1980, the direct loss ratio for Ontario is consistently higher than for other provinces.

(b) Expense Ratio

The expense ratio expresses general expenses, commissions and premium taxes as a percentage of net premiums earned. This ratio provides an indication of a company's efficiency.

TABLE 3
Expense Ratio of Property-Casualty Insurers
(Per Cent)

	<u>1984</u>	<u>1983</u>	<u>1982</u>	<u>1981</u>	<u>1980</u>	<u>1979</u>	<u>1978</u>
Ontario Insurers	32.0	30.2	29.6	32.9	32.3	32.2	32.7
Total Canada	34.2	33.3	33.0	34.9	35.1	34.1	33.8
U.S. average (*1)	28.9	29.1	28.7	28.0	27.0	26.0	25.8
Provincial Government Insurers							
- Automobile	14.1	13.7	14.2	13.1	16.0	17.3	16.2
- General	41.1	41.5	37.1	35.2	33.6	33.9	34.8
- Total	17.6	17.2	17.0	16.1	18.6	19.9	19.0

*1 Source: 1980 to 1984: Best's Review, Property and Casualty Insurance Edition, January 1986 and May 1985. 1979 and 1978: SIGMA/Swiss Re 9/85 and 9/84. (Calculated on a direct written basis as opposed to an earned basis).

Source: Annual Reports of The Superintendent of Insurance, Federal and The Province of Ontario; Annual Statements of Provincial Government Insurers.

Bearing in mind that expense ratios are related to the size of premiums, the table indicates:

- (i) The Ontario insurers have consistently achieved lower expense ratios than the industry in Canada.
- (ii) U.S. insurers have maintained a much lower expense ratio than total Canada or Ontario with an expense ratio consistently below 30 per cent.
- (iii) Government insurers have the lowest expense ratios, being primarily in automobile insurance, a traditionally low-expense line of insurance.

Quarterly results for 1985 released by Statistics Canada indicate the 1985 expense ratio for total Canada at 32.3. Statistics for Ontario insurers are not yet available. (Source: Insurers' Advisory Organization, Quarterly Report, March 26, 1986).

Expense Ratio - By Line

We were unable to extend the analysis of the expense ratio on a line by line basis for Ontario based on our sample of data. However, such information was available from the Insurance Bureau of Canada on a Canada-wide basis by major insurance class for a sample of 50 companies. Expenses here are expressed as a percentage of direct net written premiums as opposed to net earned premiums as is the case in our determination of the expense ratio detailed in Table 3. The expense ratio is indicated below for major lines for 1982 to 1984; data for other years was not available:

TABLE 9
Expense Ratio of Property-Casualty Insurers - By Line
(Per Cent)

	<u>1984</u>	<u>1983</u>	<u>1982</u>
Personal	37.4	37.0	36.7
Property other	41.4	41.9	41.1
Automobile	26.1	25.4	24.6
Other	37.1	37.0	37.3
All Lines Combined	32.1	31.7	31.3

Source: Insurance Bureau of Canada.

The results from the table indicate:

- (i) On a line by line basis, expenses are a consistent percentage of the premium dollar.
- (ii) Expenses for automobile insurance are less in relation to the premium dollar than expenses for other lines of insurance.

(c) Underwriting Ratio

The underwriting ratio expresses claims, general expenses, commissions and premium taxes as a percentage of net premiums earned.

TABLE 10

Underwriting Ratio of Property-Casualty Insurers
(Per Cent)

	<u>1984</u>	<u>1983</u>	<u>1982</u>	<u>1981</u>	<u>1980</u>	<u>1979</u>	<u>1978</u>
Ontario Insurers	113	104	106	116	108	104	100
Total Canada	113	104	108	116	110	104	98
U.S. average (*1)	117	111	108	105	102	98	95
Provincial Government Insurers	111	111	113	114	125	115	106

*1 Source: 1980 to 1984: Best's Review, Property and Casualty Insurance Edition, January 1986 and May 1985. 1979 and 1978: SIGMA/Swiss Re 9/85 and 9/84.

Source: Annual Reports of The Superintendent of Insurance, Federal and The Province of Ontario; Annual Statements of Provincial Government Insurers.

The results from the table indicate:

- (i) Ontario's underwriting ratio is similar to those achieved in total Canada, which is due to the combinations of lower expense ratios and higher loss ratios described in the preceding sections.
- (ii) The overall underwriting performance of the Canadian industry has been exceeding 100 per cent since 1979. In other words, there has been total reliance on investment income since that time.
- (iii) The United States enjoyed significantly lower underwriting ratios than both Ontario and Canada for the period from 1978 through to 1981.
- (iv) The provincial government insurers' underwriting ratio has significantly exceeded the Ontario and Canadian ratios in five of the last seven years.

Quarterly results for 1985 released by Statistics Canada indicate the 1985 underwriting ratio for total Canada at 115.3 per cent. Statistics for Ontario insurers are not available (Source: Insurers' Advisory Organization, Quarterly Report, March 26, 1986).

Investment Performance

The income that an insurer earns on its investment portfolio has a significant impact on its overall profitability. With underwriting ratios often in excess of 100 per cent, the amount of investment income determines the amount of the insurers' profit.

TABLE 11Pre-Tax Investment Income as a Percentage
of Net Premiums Earned

	<u>Ontario</u>	<u>Total Canada</u>
1984	17.9	17.7
1983	16.1	17.3
1982	15.4	16.4
1981	15.8	18.5
1980	14.9	15.7
1979	14.9	15.0

Source: Annual Reports of The Superintendent of Insurance, Federal and The Province of Ontario.

TABLE 12Pre-Tax Investment Income as a Percentage
of Average Total Investments

	<u>Canadian Mid-Term Pre-Tax Corporate Bond Yield</u>	<u>Ontario</u>	<u>Total Canada</u>
1984	13.2	11.2	11.2
1983	12.0	11.0	11.7
1982	15.6	11.1	11.3
1981	16.4	10.9	12.0
1980	13.4	9.6	9.7
1979	11.0	9.4	9.1

Source: Bank of Canada Review; Annual Reports of The Superintendent of Insurance, Federal and The Province of Ontario.

These tables indicate that yield ratios experienced by the industry in Ontario are generally in line with total Canadian insurers but overall yield ratios are consistently below yields of mid-term corporate bonds.

Equity Position in the Industry

The data in the table below strongly support the contention that the favourable growth in equity in the property-casualty industry was mainly fueled by net income. Over the period 1975 to 1985, net income, less withdrawals, is estimated to have contributed 80 per cent of the total growth in equity. In contrast, new share capital and contributed surplus contributed about 20 per cent over that period.

TABLE 13
Items Contributing to Increases in
Total Equity of Property-Casualty Companies
 (Millions of Dollars)

	<u>Net</u> <u>Income</u>	<u>Dividends</u> <u>and Head</u> <u>Office</u> <u>Transfers</u>	<u>Others</u>	<u>Income</u> <u>Less</u> <u>Withdrawals</u>	<u>Capital and</u> <u>Contributed</u> <u>Surplus</u>	<u>Increases</u> <u>in Total</u> <u>Equity</u>
1975	111	37	(109)	39	154	193
1976	277	(38)	(13)	226	76	302
1977	416	(117)	26	325	45	370
1978	443	(83)	61	421	91	512
1979	400	(68)	(17)	315	23	338
1980	212	(55)	18	175	77	252
1981	160	(79)	43	124	118	242
1982	455	(41)	34	448	121	569
1983	741	(113)	2	630	100	730
1984	362	(140)	84	306	(52)	254
1985 (9 months)	<u>460</u>	<u>26</u>	<u>(134)</u>	<u>302</u>	<u>49</u>	<u>351</u>
Cumulative Total (1975-1985)	<u>4,037</u>	<u>(671)</u>	<u>(55)</u>	<u>3,311</u>	<u>802</u>	<u>4,113</u>
Cumulative per cent Contribution	98.2	(16.3)	(1.4)	80.5	19.5	100.0

Source: Statistics Canada, Financial Institutions, Cat. No. 61-006.

The major disbursements out of retained earnings of companies have been dividend payments to policyholders/shareholders and transfers to head offices. The latter item encompasses the remittances of dividends, management fees, and other sundry accounts to foreign parent organizations of property-casualty companies operating in Canada. Dividends and net head office transfers detracted about 16 per cent from the increase in total equity. Cumulative dividend payouts amounted to \$641 million and net transfers to head office over the period totalled only \$30 million.

The most noteworthy feature is not the level of new capital introduced, nor perhaps the level of net income. Rather, it is the high level of retention of profits in the industry that provides the solvency and financial backing over the period.

Solvency Ratios

A key solvency ratio for property-casualty insurers is the liquidity ratio. This is the ratio of total liabilities to cash and invested assets. This provides an indication of the financial stability of an insurer by measuring its ability to meet its current financial demands. The liquidity guidelines established by the National Association of Insurance Commissioners in the United States call for the ratio not to exceed 105 per cent.

TABLE 14

Liquidity Ratio
(Per Cent)

	<u>Ontario</u>	<u>Total Canada</u>
1984	79	84
1983	79	82
1982	83	85
1981	34	37
1980	30	34

Source: Annual Reports of The Superintendent of Insurance, Federal and The Province of Ontario.

Both Ontario and total Canada are well within the recommended ranges with Ontario in a slightly better position. In fact, the liquidity of both the Ontario and total Canadian insurers would appear to have improved after a slight deterioration in 1981-1982.

Other solvency ratios include the ratio of total liabilities to surplus and the ratio of net premiums written to capital and surplus. The former measures the cushion to absorb any shortfall in asset values or sudden unexpected losses. The latter indicates the degree of financial leverage used by the industry. Both these ratios indicate that Ontario is in a slightly stronger position than total Canada and that there has been a minor improvement in its liquidity position over the past five years. These results suggest that, with perhaps some minor exceptions, insurers have the financial sinews to withstand serious losses and to meet their commitments to the insuring public. Furthermore, there is additional capacity, in general, in both Ontario and the Canadian market.

Claims Reserves of Property-Casualty Insurers

The table below presents two ratios that indicate the significance of claims reserves for the period of 1978-1984 inclusive:

TABLE 15

Measures of the Significance of Unpaid Claims Reserves Relative
to Financial Operations of Insurers

	<u>*Unpaid Claims (Millions)</u>	<u>Per Cent of Total Capital</u>	<u>Per Cent of Total Assets</u>
1984	5,822	123	39
1983	4,947	110	36
1982	4,103	110	34
1981	3,929	119	36
1980	3,632	119	36
1979	3,367	122	37
1978	3,089	126	37

* Includes all major federal registered property and casualty companies plus ten Ontario licensed companies.

Source: Annual Reports of the Federal Superintendent of Insurance.

The conclusions derived from the above data are as follows:

- o Claims Reserves represent a significant portion of an insurance company's financial structure.

Historically, for all companies combined, claims reserves have represented 35-40 per cent of total assets and 100-120 per cent of total capital and surplus.

- o Claims reserves have experienced a sudden proportionate increase in 1984. This is the largest change for data that was readily available (i.e., 3 per cent of total assets, 13 per cent of total capital and surplus).
- o Reserve levels in 1984 are at or close to proportionate levels maintained in 1978. For 1979-1982, reserves gradually declined in relationship to capital and surplus and total assets.

The methods of reserve determination are undergoing a radical and fundamental change. The traditional methods represented by "rules of thumb" and "experienced guessing" are gradually giving way to the more analytical and rigorous review of actuarial science.

The estimation of claim reserve adequacy by the industry is dependent on an historical consistency of individual case reserving philosophy, claim payment rates, claim reporting rates, etc. Using an accepted reserve assessment technique, the incurred loss development method, Table 16 indicates that the claims reserves stated on the 1984 financial statements were approximately \$956 million deficient (18.7 per cent of stated reserves) on a non-discounted basis.

TABLE 16

Review of Adequacy of Industry Reserve Levels All Canada
(Federal Companies)/All Lines Estimate of
Ultimate Claims Amounts (\$000)

<u>Accident</u> <u>Year</u>	<u>Factor</u>	<u>Incurred Method</u>
		<u>Estimated</u> <u>Ultimate</u> <u>Cost</u>
1980	1.00	\$ 3,869,006
1981	1.01	4,889,616
1982	1.028	4,700,762
1983	1.047	4,647,368
1984	1.041	<u>5,347,345</u>
Total Estimate:		\$23,454,097
Total Accounted For:		<u>22,498,422</u>
- Reserve Excess (Deficiency) on a non-discounted basis		(955,675)
- Excess (Deficiency) as percentage of Stated Reserves on a non-discounted basis		(18.7)

Note: Some might argue that discounting be applied to these claims reserves. However, even the application of a discount factor of 8 per cent results in only a minor excess reserve position (1.5 per cent of stated reserves).

Source: The Wyatt Company.

There is considerable variability among insurance companies for commercial liability reserves relative to property reserve levels. This is reflective of a wide deviation of reserving methodologies and patterns between lines of business and companies.

Commercial liability reserves showed some stability relative to premiums in 1980 and 1981 with a relative decline in 1982. Years 1983 and 1984 represented sharp upward movement in reserves proportionate to premium. This upward adjustment is reflective not only of an adjustment to a suggested premature profit taking during 1981-1982, but of the increased uncertainties regarding commercial liabilities that began to become evident during that period (see Chart 10).

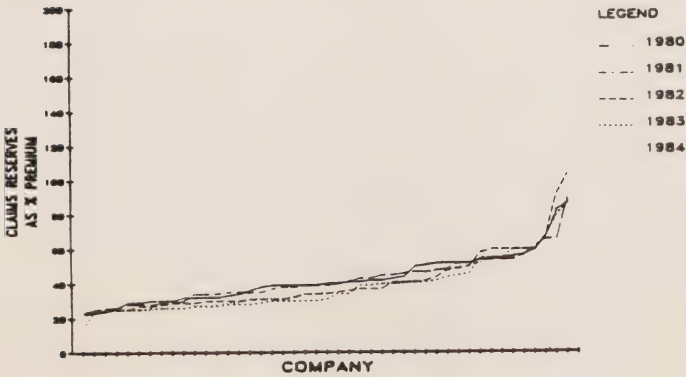
CHART 10
Commercial Liability Reserve Variability
Among 34 Canadian Companies



Source: 1985 Insurance TRAC Report.

Property reserves relative to premiums show a great deal more stability both among companies and from year to year than does liability (see Chart 11). Property reserves have, in the main, been keeping the same relative position to premiums over the years 1980-1984.

CHART 11
Property Reserve Variability Among
34 Canadian Companies



Source: 1985 Insurance TRAC Report.

Recent Failures of Property-Casualty Insurers

Until 1980, Canada had experienced only a few failures in the property-casualty insurance industry in fifty years. The 1980s, however, have seen a spate of insurance company failures, such as:

Cardinal Insurance Company;
Northumberland General Insurance Company;
The Pitts Insurance Company; and
and Strathcona Insurance Company.

In addition, at least two other entities failed for reasons other than local insolvency. These entities were the United Canada Insurance Company and the Canadian branch of Ideal Mutual Insurance Company. In both instances, the main company, or parent company in the United States, failed and, largely as a result, the Canadian operations had to be liquidated. To our knowledge, both were solvent at the time that they were liquidated.

Furthermore, there have also been at least thirteen recent voluntary wind-ups of insurance companies in which insolvency was not the major cause. In most cases, insurance companies or branches were dissolved for reasons such as merger with another insurance company or domestication of a Canadian branch into a related Canadian insurance company.

In summary, we believe that it is fair to say that the most prevalent cause for insurance company failure is the relationship of an insurer with related companies, either by way of management agency contracts or reinsurance, resulting in liquidity problems. Fortunately, the total business of the failed insurance companies has been insignificant to the total industry.

Reinsurance Companies

In contrast to the long history of primary insurers based in Canada, the first specialized reinsurance companies in the country were only established in the post-1945 era.

TABLE 17
Reinsurance Companies in Canada
(1979 - 1984)

<u>Year</u>	<u>Number of Companies</u>	<u>Net Premiums Written</u>		<u>Gross Premiums Assumed (\$000)</u>	<u>Underwriting Profit/Loss (\$000)</u>	<u>Investment Income (\$000)</u>	<u>Operating Profit (\$000)</u>
		<u>(\$000)</u>	<u>Per Cent Change</u>				
1979	23	369,798	4.0	538,257	-20,585	67,130	46,545
1980	30	447,275	21.0	641,992	-57,808	85,823	28,015
1981	39	565,681	26.5	817,992	-110,906	113,373	2,472
1982	42	669,769	13.4	961,456	-85,278	150,743	65,465
1983	46	654,145	-2.3	1,098,419	-85,593	166,161	30,568
1984	47	684,585	4.7	1,107,264	<u>-93,905</u>	<u>183,633</u>	<u>39,728</u>
Cumulative six-year totals					<u><u>-454,075</u></u>	<u><u>766,868</u></u>	<u><u>312,793</u></u>

Source: Canadian Insurance/Agent and Broker, Annual Statistics (1980-1985).

In the recent past, the number of reinsurance companies doubled from 23 in 1979 to 47 during 1984. For the latest year, reinsurance companies assumed gross premiums of \$1.1 billion and wrote net premiums that amounted to \$685 million.

An easy market in reinsurance was much in evidence during 1980 to 1982 as net premiums averaged an annual growth of about 22 per cent. Reflecting the lagged effects of the contraction of world reinsurance markets, there was a sharp correction in net premiums written during 1983 which have since remained relatively flat.

Similar to, and indeed a reflection of, the underwriting experience of primary insurers, reinsurance companies suffered consistent underwriting losses. Over the six-year period 1979 to 1984, the cumulative underwriting loss totalled \$454 million, only to be offset by \$767 million in investment income.

The aggregate results suggest that the Canadian reinsurance industry is solvent and profitable. However, certain deviations from this norm may occur in specific business lines within individual companies.

7.4 Proximate Explanation of Cycles of Availability, Price and Profitability

The Claims Experience

The property-casualty insurance industry has had an adverse experience with claims over the last decade. In the recent past, 1980-1984, claims growth for all lines of business averaged 10.0 per cent per year whereas net premiums earned increased only 9.5 per cent. The trends, however, have been distinctly unfavourable as claims growth exceeded that of premiums by a multiple of roughly three times during 1984.

Key factors that determine the claims experience of property-casualty insurers are:

- o the number and size of court awards;
- o the number of claims paid out of court;
- o the average value of claims paid; and
- o the frequency of claims incurred.

Recently, court awards, although small in relation to total claims, have biased upwards the majority of out-of-court settlements. Judicial developments such as the reform of the Family Law Act and the "Spills Bill" have only recently had an impact on the settlements experience but they are expected to have a major impact in the future.

Table 13 provides an overview of the claims experience over the period 1980-1984 for selected classes. The crisis in claims associated with liability insurance is clearly evidenced by the fact that the average growth in such claims exceeded the average by a wide margin. High claims growth for mortgage insurance can be readily explained by the unprecedented rise in interest rates and the severe recessionary experience of the early 1980s.

TABLE 13
Claims Experience by Selected Class
(1980-1984)

<u>Class</u>	<u>Cumulative (Net) Losses Incurred (\$ Millions)</u>	<u>Average Annual Growth in Claims (Per Cent)</u>	<u>Average Loss Ratio (Per Cent)</u>
Automobile	12,936	10.6	81.5
Property	8,137	6.1	67.1
Liability	2,017	24.4	85.1
Mortgage	415	27.1	238.5
Wet Marine	200	4.5	74.5
Aircraft	190	0.9	73.1
Boiler	138	16.1	44.2
Guarantee (Surety)	120	15.3	34.7
<u>All Classes Combined</u>	34,048	10.0	79.3

Source: Canadian Underwriter, 52nd May Statistical Issue, May 1985.

The availability of good claims/loss cost statistics for automobile coverage facilitates the identification of the key determinants of the recent experience in the largest business line. Several conclusions can be drawn from the evidence presented in Tables 19 and 20:

- o Large claims do not appear to be, in themselves, a reason for rapid increases in overall claims. Their effect on influencing the standards for out-of-court settlements is much more substantial.
- o The frequency of claims declined over the period 1981-1983 and has subsequently edged upwards. When viewed over the entire period 1981-1985, frequency of claims is not a contributing factor to claims growth; however, the recent upturn during 1984 and 1985 has definitely contributed to overall claims growth.
- o The average cost per claim has risen substantially and is the critical factor underlying overall automobile claims growth.
- o Not only is the average cost per claim in Ontario roughly 1.75 times the level of that in Alberta and the Atlantic provinces, but the rate of growth is also two or three times that of the other provinces.
- o The frequency of claims in Ontario was roughly the average experience in Canada during 1981-1983 and exceeded the average Canadian experience during 1984-1985. It has tended to be higher than that of the Atlantic provinces throughout and lower than the Alberta experience during 1981-1982 while higher during 1983-1985.

TABLE 19
Loss Experience for Claims Exceeding \$50,000

<u>Policy Year</u>	<u>Estimated Ultimate Number of Claims</u>	<u>Estimated Ultimate Total Value of Claims (\$ Thousands)</u>
<u>Private Passenger</u>		
1981	1,167	\$139,182
1982	1,270	205,162
1983	1,381	235,878
1984	1,325	235,055
1985*	1,042	240,737
<u>Commercial</u>		
1981	142	28,525
1982	117	22,137
1983	125	24,040
1984	117	18,071
1985*	105	24,949

* Preliminary estimate for policy year 1985, subject to substantial upward revisions.

Note: These figures were calculated on the assumption that the ultimate period of claims development is 42 months.

Source: Green Book: The Automobile Experience, Insurance Bureau of Canada, 1985.

TABLE 20

Trend or Loss Cost Exhibits, Third-Party Liability
Private Passenger Automobiles — Excluding Farmers
Bodily Injury and Property Damage Liability Combined

<u>Province</u>	<u>Policy Year</u>	<u>Number of Cars Insured</u> (1)	<u>Claim Frequency per 100 Cars Insured</u> (2)	<u>Average Cost per Claim</u> (3)	<u>Loss Cost per Car Insured</u> (4)
ALBERTA	1980	967,498	6.97	1,958	136.50
	1981	1,040,571	6.94	2,205	153.00
	1982	1,085,644	6.34	2,207	139.37
	1983	1,096,235	5.34	2,531	135.12
	1984	1,123,885	5.20	2,520	131.08
ATLANTIC PROVINCES	1980	748,385	6.05	1,810	109.46
	1981	763,043	6.15	1,958	120.47
	1982	773,399	5.62	2,036	114.48
	1983	787,105	5.17	2,435	125.95
	1984	819,179	5.39	2,400	129.30
ONTARIO	1980	3,420,996	6.80	2,336	158.33
	1981	3,475,637	6.69	2,701	180.68
	1982	3,513,521	5.96	3,063	182.48
	1983	3,597,887	5.46	3,828	209.06
	1984	3,732,117	5.39	4,330	255.01
COUNTRYWIDE EXCLUDING QUEBEC	1980	5,136,879	6.72	2,193	147.43
	1981	5,279,256	6.66	2,500	166.52
	1982	5,372,564	5.99	2,741	164.08
	1983	5,481,227	5.40	3,379	182.34
	1984	5,725,181	5.68	3,743	212.70

Policy Years cover a fiscal-policy year statistical period; for example, "1985" consists of policies effected in the 12 months from July 1, 1984 through June 30, 1985.

Source: Green Book: The Automobile Experience, Insurance Bureau of Canada, 1985.

Expense Developments

Expenses that property-casualty insurers experience which are not related to claims and adjustments are: operating expenses, taxes, licences and fees, and commissions. In section 7.3 we reviewed the expense ratio, which expresses such expenses as a percentage of net premiums earned. Over the period 1978-1984, the expense ratio for total Canada averaged 34.1 per cent. The experience during 1984 varied considerably by business line: from a low of 26.1 per cent for automobile coverage, the expense ratio extended to a high of 41.4 per cent for commercial property (see Table 9).

The fairly stable relationship observed between general expenses and net earned premiums over the period 1978-1984 suggests a fairly stagnant productivity situation. That is, the level of inputs (expenses) for a given level of output (earned premiums) has remained stable. This situation is readily explained by the structure of the property-casualty market and the resulting lack of economies of scale.

Commissions

During 1984, commissions were 14 per cent of total net premiums earned. At first glance, this level appears to be rather high and indicates an inefficient system of distribution of risk protection products to the public. Furthermore, the high and stable commission rate also signifies a constraint in the ability of the marketplace to deliver cost-efficient services to the public by narrowing margins. It is, however, argued that existing commission rates are by no means excessive, as they essentially cover costs of the substantial follow-up service activity that is involved in providing property-casualty insurance products, particularly for automobile coverage.

TABLE 21
Commission Rates by Line of Business: 1984
(Per Cent)

Automobile	11.8
Commercial Property	19.8
Personal Lines Property	20.3
General Liability	18.3
All Lines Combined	13.0

Source: Insurance Bureau of Canada.

The wide discrepancy in commission rates by line of business is, however, reflective of the degree of competition in that segment of the market. Commission rates are lowest for automobile policies, where the market is the most competitive. Enhanced competition among existing and alternate distribution channels would, therefore, benefit the policyholder measurably.

Reinsurance Costs

Two major developments in reinsurance markets in the 1980s have shaped the current situation. First, the easy market in reinsurance that prevailed in the early 1980s saw reinsurance costs fall in the face of new capacity from unregistered and non-traditional reinsurers. There was evidence of abuse of this new capacity, particularly in liability lines where a disproportionate share of risks was transferred to the reinsurer with ultimately negative results. Second, the underwriting experiences of reinsurers deteriorated considerably with a consequent general withdrawal of capacity and a total withdrawal in certain liability lines. In fact, the coverage offered by

non-traditional reinsurers has all but disappeared. The sum total of these developments has been a marked rise in reinsurance costs in most lines and substantial increases in certain lines where residual reinsurance is still offered.

These developments are clearly illustrated for Ontario insurers in the diverging trends in Table 22. While the percentage of direct premiums written ceded to reinsurers has declined since 1980, the reinsurers' share of the claims expenses has grown disproportionately. These market experiences, along with preliminary indications that Ontario is converging to the litigious environment of the United States, have not gone unnoticed by international reinsurers.

TABLE 22
Ontario Insurers' Reinsurance as a Percentage of

	<u>Direct Premiums</u> <u>Written</u>	<u>Direct Claims and</u> <u>Adjustment Expenses</u>
1984	33	41
1983	31	37
1982	32	32
1981	36	33
1980	38	29

Source: TRAC 1985, The Wyatt Company.

The perceptions held by Lloyd's about continuing business relationships with North America and Ontario are noteworthy and are representative of international reinsurers. Such perceptions are also a harbinger of cost and availability conditions well into the future. These largely unfavourable views can be summarized as follows:

- o Generally, the Canadian insurance market is not distinguished from the United States.
- o It is generally considered that premium rates will continue to escalate.
- o There appears to be little further capacity in the London market for liability risks, particularly emanating from North America.
- o Lloyd's has been withdrawing over the past ten years from the North American liability insurance market, with only a few risks remaining.
- o It is generally considered that Lloyd's will not return to the North American liability insurance market for many years, if ever.

Industrial Structures and Dynamics of Adjustment

The Canadian property-casualty insurance industry can be easily and accurately described by the competitive market model. The characteristics of such a market model are:

- o It is highly fragmented, with no one company or small group of companies having any significant market power;
- o It lacks any economies of scale; and
- o It is devoid of any significant barriers to entry for either domestic or foreign companies.

This competitive characterization of the industry puts into perspective the behaviour and performance that we currently observe. As we would anticipate, the lack of barriers to entry and aggressive pricing behaviour by the industry have led to the build-up of excess capacity for most product lines. The extreme competitiveness in the industry also ensured that aggressive pricing continued despite protracted losses on underwriting until capacity constraints emerged or solvency conditions became critical. The predominant distribution channel of the industry, general agents/brokers, was also a key factor in allowing premium rate inadequacy to persist due to the discretion they possessed in directing business to the low-cost producer.

Shocks to the Property-Casualty Insurance Market

The recent cyclical downturn in the property-casualty industry was exaggerated by a set of conflicting factors, internal and external to the industry. These factors impeded the inherent self-corrective mechanisms in the industry that usually work towards alleviating cyclical problems. Unfortunately, events have combined to create structural problems in the market which are critical and which require specific and focused policy solutions. In this section we will review the series of shocks that the property-casualty market was subjected to over the recent past:

(a) Value of Claims

As discussed earlier, the increasing value of claims rather than the frequency was primarily responsible for rising automobile claims. Various other environmental disasters and the accumulating experience of long-tail liabilities have aggravated recent claims costs.

(b) Reserves

The general deficiency of claims reserves, discussed in section 7.3, is a growing concern for the industry. This inadequacy was a result of the widely divergent reserving techniques utilized, underestimated claims payments, and probable premature profit taking. As reserve inadequacy was particularly acute in liability lines, it has undoubtedly contributed to the "capacity crunch" in those lines.

(c) **Interest Rates**

The relatively high interest rates since the late 1970s have buoyed the investment income picture of property-casualty insurance companies. This development has helped offset growing underwriting losses and kept most companies solvent. It is also conjectured that high investment earnings, acting as a wide safety buffer, have contributed to the injurious competitive pricing and underwriting practices by the industry. In other words, this safety buffer allowed the emphasis behind premium setting to shift from covering actual liabilities to gaining market share in premiums. Indeed, the expectations of increased investment income had a profound impact on the management psychology that allowed consistent annual real declines in premium rates of 2.0 to 2.5 per cent.

(d) **Reinsurance Prices**

The "reinsurance crunch" that became evident in Canada in 1984-1985, two to three years after the similar experience in international and United States markets, led to marked increases in reinsurance costs. These price increases, combined with a withdrawal of available capacity, have had their most pronounced impact on liability lines.

(e) **General Economic Conditions**

The steepest business cycle downturn in Canada since the 1930s occurred during 1981-1982. A combination of worse inflationary and productivity experiences than our major trading partners helped accentuate the downturn. Employment losses in 1982 were dramatic and an indicator of the economy correcting the productivity malaise through dislocations in inefficient sectors. The severe dislocations, caused as significant segments of the labour force were forced to participate in the industrial re-adjustments, contributed in a measurable way to the massive rise in liability claims. Another key contributing factor arises from the frictions associated with the adjustments that businesses themselves underwent as the financially weak and inefficient were weeded out. As most of this turbulent adjustment period is behind us, the outlook is for a relatively stable period and, consequently, these factors will play a lesser role in future liability claims.

Perhaps the most serious and lingering effect of the excess inflation period of the 1970s is on the settlements and pre-judgment interest awarded in liability claims. While the powerful and pervasive effects of the disinflationary trend have taken hold in most markets, they have not done so in the administrative system of civil justice. A closer examination of recent awards of high claims reveals an implicit expectation of future inflation rates in the 3 to 9 per cent range. This can seriously bias settlement costs upwards when realistic expectations of long-term inflation continue to be in the 4 to 5 per cent range.

(f) **Exchange Rates**

The Canadian dollar has experienced a major depreciation against the strong currencies of the world over the last decade. At current levels, the Canadian dollar has experienced a cumulative depreciation of about 30 per cent relative to the United States dollar and roughly 52 per cent against the Japanese yen.

It can be reasonably argued that our depreciating currency has had some direct implications for the property-casualty industry, most notably on claims costs. The lower dollar has resulted in higher import costs for automobiles and automobile parts. This trend has been particularly pronounced due to the sharp deterioration against the Japanese yen and the rising market share of Japanese imports. The lower dollar has not had its effects limited to offshore import costs; North American automobile costs have also reflected the deterioration against the United States dollar. The sum total of these experiences is that claims costs associated with automobile coverage have been exacerbated by currency fluctuations.

(g) **Changes in Laws and Regulations**

The reform of the Family Law Act in Ontario has clarified a whole new set of rights and claims which will undoubtedly affect the frequency and value of settlements. In addition, the recent enactment of the environmentally related "Spills Bill" has created tremendous uncertainties for insurers attempting to quantify the expected liability fall-out. While desirable from a social standpoint, these changes in laws were poorly timed from the property-casualty industry's position of already addressing a severe underwriting downcycle. These changes should bias premium rates upwards.

Federal and provincial regulators have already raised capitalization requirements for property-casualty insurers in response to recent insolvencies. Various regulatory changes that govern the use of reinsurance and limit the operations of the unregistered reinsurer are under consideration. The resulting effect of all these changes is to engender a financially stronger industry but limit the introduction of new capacity.

APPENDIX 8

AN OVERVIEW OF METHODS AND ESTIMATES OF CLAIM
RESERVE LIABILITIES FOR THE PROPERTY/CASUALTY
INSURANCE INDUSTRY

April 10, 1986

W. R. ANDRUS
THE WYATT COMPANY

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PAPER TO THE TASK FORCE ON INSURANCE

The adequacy of claims reserves of the property/casualty insurance industry.

A/ SUMMARY

The conclusions derived and supported herein are as follows:

- Claims Reserves represent a significant portion of an insurance company's financial structure.

Historically, for all companies combined, claims reserves have represented 35%-40% of total assets and 110%-120% of total capital and surplus.

- Claims reserves have experienced a sudden proportionate increase in 1984. This is the largest annual change for data that was readily available (i.e. increases of 3% of total assets, 13% of total capital and surplus over 1983 levels).
- Reserve levels in 1984 are at or close to proportionate levels maintained in 1978. For the years 1979-1982, reserves gradually declined in relationship to capital and surplus and total assets.
- Accurate quantification of reserves is a difficult and complex science. This difficulty is further exacerbated by the various vested interests having influence on the final reserve determination.
- The methods of reserve determination are undergoing a radical and fundamental change. The traditional methods represented by "rules of thumb" and "experienced guessing" are gradually giving way to the more analytical and vigorous review of actuarial science.

This change has been fueled by both economic and judicial inflation and more recently by regulators and insurance industry leaders.

- The actuarial methods are constrained to some degree by the characteristics of certain lines of business combined with poor insurance company internal management information systems. These constraints will be overcome in the foreseeable future, assisted in part by regulators demanding actuarial reserve certification and insurers themselves moving to state-of-the-art information systems.
- Using two generally accepted reserve assessment techniques it can be shown that the claims reserves stated on the 1984 financial statements were approximately \$956 million deficient (18.7% of stated reserves) on a non-discounted basis.

- It is shown that reserve methods vary greatly among insurance companies for commercial liability business. The minimum/maximum range is consistently in the range of 1-3 times.
- Commercial liability reserves showed some stability relative to premiums in 1980 and 1981 with a relative decline in 1982. Years 1983 and 1984 represented sharp upward movement in reserves proportionate to premium. (Refer to Appendix II).
- Property reserves relative to premiums show a great deal more stability both among companies and from year to year than does liability. Property reserves have, in the main, been keeping the same relative position to premiums over the years 1980-1984 (Refer to Appendix II).
- There is an equity on the balance sheets of insurers that is not accounted for. This equity is the difference between the stated reserves and the present value of the ultimate disposition of the claims. The value of this equity is dependent on:
 - i) adequacy of stated reserves
 - ii) interest rate assumptions
 - iii) assumed future payout stream of claim liabilities.

Calculations are presented in this report to show that this equity at the end of 1984 had a value of \$77-464 million. This range represents interest rate assumptions of 8%-12% respectively. (Refer to Appendix IV).

The most accurate interest rate to use at a given point in time is that which results from scheduling fixed income maturities to match the assumed payout rate, thereby immunizing against reinvestment risk.

This paper assumes that at December 31, 1984, this rate of interest was in the range of 8%-12%.

B/ INTRODUCTION

The purpose of this report is to present comments on the adequacy of claims reserves of various parts of the industry.

This paper will highlight the relevant concepts underlying the reserve determination process and present various measures of adequacy.

It also provides an overview of the forces creating the cyclical nature of over - and underprovision of reserves.

C/ RESERVES - SIGNIFICANCE ON AN INSURER'S FINANCES

Table 1 below presents two ratios that indicate the significance of claims reserves for the period 1978-1984 inclusive.

Table 1
Measures of the Significance of
Unpaid Claims Reserves
Relative to Financial Operations of Insurers

<u>Year</u>	<u>*Unpaid Claims (millions)</u>	<u>% of Total Capital</u>	<u>% of Total Assets</u>
1984	5,822	123	39
1983	4,947	110	36
1982	4,103	110	34
1981	3,929	119	36
1980	3,632	119	36
1979	3,367	122	37
1978	3,089	126	37

* Includes all major federally registered property and casualty companies plus 10 Ontario licensed companies.

This data indicates that:

- (i) Claims reserves are a major element of an insurance company's finances.

This item alone accounts for over 1/3 of total assets and over 110% of total capital.
- (ii) The reserve levels at the end of 1984, while experiencing a sudden upward movement from 1983 levels, were only at or close to the proportionate levels of 1978.
- (iii) The period of 1980-1983 shows a progressive relative decline in reserve levels. It can be argued that the reserve corrections experienced in 1984 and possibly in 1985 (data as yet unavailable) were due to premature profit taking in the 1980-1983 period.

D/ RESERVES - OPPOSING FORCES

The determination of adequate claims reserve liabilities has numerous opposing forces.

These forces and their effects are discussed below.

Insurance Regulatory Authorities

The primary interest of this body is protection of the public by assurances that the company has sufficient monies to pay all claim liabilities. Therefore, the thrust is to ensure a conservative level of reserve setting. The regulatory authorities perform periodic reviews of a company's historical record of reserving accuracy and make their views known to senior management. In cases where warranted, the regulator has encouraged the company to obtain the opinion of an independent casualty actuary. The regulators, both federal and provincial, are taking much stronger steps in this regard in that legislation requiring actuarial certification of the loss reserves has been drafted and is expected to be enacted within 1-2 years from the date of writing.

Taxation Authorities

Insurance companies are allowed to establish **pre-tax** claims reserves as a cost of doing business. The tax department is a strong influence on insurers to minimize reserves for fear of incurring penalties (fines) and the embarrassment associated with corporate tax reviews.

Several Ontario-based Canadian insurers have recently been under investigation from taxation authorities. All cases have resulted in considerable expense to the insurers yet most have been concluded in favour of the insurer.

After this latest round of challenges from the tax authorities, insurers appear to have obtained a reasonably firm tax ruling confirming that reserves for losses that have occurred, but are not yet reported, qualify as a pre-tax expense, yet this is still open to challenge if the tax authorities feel the system is being abused.

Catastrophe reserves have not attained this pre-tax qualification. The author is not aware of any rulings, pro or con, by the tax authorities on the issue of catastrophe reserves but research of the insurance company's management has confirmed that there is virtually unanimous opinion indicating an unfavourable tax consequence should a company try to achieve such a deduction.

The task force chose a catastrophe situation (hail storm) as a specific case study. This case was that of Ontario greenhouses centrally located in the Tillsonburg area. These greenhouses are exposed to potential total devastation by climatic events due to their extreme geographic concentration and there was such a storm in May 1985 causing approximately \$11 million in insured damages. The insurers therefore suffered an extremely severe underwriting loss in 1985 and, notwithstanding profits realized in prior years, were extremely reluctant to continue providing insurance to these properties.

The pricing of the catastrophic insurance product is dependent on assuming a certain frequency of severe climatic occurrences. Valid arguments can be made that the companies should be allowed to expense the claims experience on the same assumptions used in setting the premium. A favourable ruling by the tax department in this regard would substantially contribute to the removal of the supply/profit instability of natural catastrophe insurance.

Shareholders

Shareholders' primary interest lies in maximizing the rate of return on their investment. Therefore their influence tends to a minimization of reserve levels.

To the extent that company management are shareholders or are remunerated directly in proportion to shareholders' gains, this reserve minimization can often lead to understatement.

Management, by lowering reserves, convinces shareholders that the business is generating profits. Shareholders then respond by encouraging management to write more premiums under the expectation of increasing profit. Management responds by reducing premium levels to attract competitors' business which, of course, only makes it more difficult to immediately recognize the reserve shortfall.

This process, commonly referred to in the industry as "cash flow" underwriting, only contributes to make the underwriting cycle more volatile.

It is widely perceived that the 1985/1986 market shortage/price increases are the effect of such practices carried on in 1980-82 culminating in a sudden realization of reserve shortfall in 1984 and 1985.

The graphs shown in Appendix II referring to Liability Reserve Variability confirms this activity.

Brokers (Intermediaries)

Insurance intermediaries are contractually remunerated by a flat "up front" commission and a "profit" commission on the business forwarded to the insurer.

Since the reserves directly affect profit, the brokers exert an influence to minimize reserves and thereby exaggerate profit and their remuneration. The insurer is often forced to recognize this or face losing considerable business to a competitor with less conservative reserving standards.

Brokers exert an influence in that they tend to move insureds to the lowest- priced insurers. Invariably the lower- priced insurers are identified in the long term as companies with more liberal reserving standards.

E/ DETERMINATION OF RESERVES

Traditional Methods

The determination of adequate reserves is a problem as old as the insurance business itself. Insurers have traditionally faced the challenge in a rather simplified non-vigorous manner. The traditional methods include assessing case reserves on individual merit plus a "rule of thumb" for IBNR reserves.

The "rules of thumb" included:

- (i) 1 or 2 months' premium(s)
- (ii) a fixed percentage of total case reserves
- (iii) a fixed percentage of premiums written which varies by line of business.

The reserve levels so determined were reasonably stable from one year to the next and as such did not command extraordinary attention. Consequently the insurance industry did little to enhance its ability to follow claims development by designing superior state-of-the-art data bases or by incorporating a sophisticated level of statistical/actuarial analysis into its reserve setting process.

The shortcomings of traditional methods became apparent during the period of high inflation (economic and judiciary) extending from the middle of the 1970s to the present day yet, many insurers (especially smaller ones) have delayed recognition of this situation until 1984/1985 citing either competitive market forces or sudden and dramatic court decisions as the main reason for inaction.

Actuarial Methods

- General Background

Most of the larger insurers have turned to acquiring actuarial expertise to assist in determining levels of claims reserves. Today virtually all of the top 25 insurers in Canada have this discipline on staff.

The actuarial profession is specifically trained in the science of determining adequate levels of claims reserves.

The Canadian Institute of Actuaries recently published a set of recommendations for determining property/casualty insurance company reserves.

It is the intent of the Institute to review the recommendations after a one-year trial period and make improvements where indicated.

A copy of these recommendations is attached as Appendix I.

While it is beyond the scope of this paper to present the technical detail used by actuaries, they generally examine historical emergence patterns of claim development. This body of data is adjusted for all significant changes to allow a simulation of historical development given current conditions (i.e., judicial awards, pre-judgment interest, inflation, etc.). This adjusted data is then used as an approximator of ultimate claim disposition from which indicated reserve levels are calculated.

It is basic to the actuarial process that numerous methods be used to develop a range of likely outcomes and attempt to identify any underlying convergence of indications.

- Credibility

Smaller insurance companies are often exposed to very wide ranges of possible outcomes when measured strictly on their own historical record. Actuaries refer to this difficulty as a lack of statistical credibility and seek to overcome this by referring to larger bodies of similar data. This can often take the form of industry-wide experience but is often limited by the availability of appropriate industry data.

This data shortcoming is referred to later in this report.

- Applicability to Lines of Business

The methods used by actuaries are ideally suited for those lines of business where:

- (i) individual exposure units are relatively homogeneous;
- (ii) there is a reasonably high degree of claim activity;
- (iii) claim data is available in various known layers. In other words, the data should be adjusted for infrequent "shock claims".

Automobile and property insurance are ideal applicants for actuarial methods. Since these two lines of business account for the majority of insurance premiums in Canada, the industry's actuaries have focused their energies into this area.

Commercial liability does not have the statistical credibility or homogeneity of the two major insurance lines and consequently the insurers have widely ranging approaches to setting these reserves.

F/ DATA CONSTRAINTS

A data base sufficient to review and assess claim reserve adequacy should have at least the following detail available:

- (i) Accident year/development year
- (ii) Line of business (at minimal detail level of regulatory financial statement or finer)
- (iii) Claims expenditures divided by
 - amounts paid - closed and open claims
 - allocated adjustment expenses - paid
 - outstanding reserves allocated by claim file.

The claim expenses identified above should be available before and after accounting for the effect of reinsurance.

- (iv) Claim counts provided in same detail as item (iii).
- (v) Exposure data by accident year (eg. car-year, house-year, # lawyers - professional liability, # beds - hospital insurance, etc.)
- (vi) Premium data by accident year.

Only the larger and more technologically sophisticated insurers have an internal data base meeting these minimal requirements.

There has, in the past, been an absence of "recognized need" for insurers to invest the necessary resources to enhance the internal management information systems.

The pressure for more refined data comes usually from two sources:

- regulatory
- industry association.

The regulators prescribe a standard financial statement to be completed by all licensed insurers within the domain of the regulatory body.

Both federal and provincial regulatory statements require historical claim development experience but at an extremely low level of detail. A copy of such an exhibit is attached as Appendix V.

The major shortcoming of this exhibit is that it combines all lines of business into one exhibit. Consequently the analytical value of this exhibit is very limited for all but the largest of companies.

Industry associations have produced and maintain detailed statistical plans. The detail available in these plans exceeds the requirements presented above.

Unfortunately the associations have not shown an interest in providing the individual insurer members with claim development detail reports. Reasons given for this inaction include competitive pressures between association members, extra expense to the association, inaccurate data, etc.

It is reasonable to expect that if actuarial certification of reserves is required this will apply significant pressure to both insurers and associations to enhance the quality of information available to this process.

The regulators could also contribute to accelerating the data enhancement by requiring accident year data by line of business. This requirement has been in effect for some time with the U.S.A. regulatory bodies.

G/ REVIEW OF ADEQUACY OF INDUSTRY RESERVE LEVELS

Appendices III and IIIA present the technical calculations to determine the undiscounted claims reserves using the only accident year data available from the Federal Department of Insurance.

Two estimation methods are used, namely:

- (i) incurred loss development; and
- (ii) paid loss development.

Each of these methods is dependent on an historical consistency of individual case reserving philosophy, claim payment rates, claim reporting rates, etc.

While there is not sufficient detailed data available to completely validate the underlying consistency, Appendix III does present remarkable stability in the Net Claims Incurred development factors. The stability is evident throughout the history whereas the Net Claims Paid method only achieves stability after 48 months of development.

Appendix IIIA shows both methods indicating a substantial reserve deficiency at the end of 1984. Because of the above-noted superior stability, the incurred method is suggested as producing the more accurate result.

Consequently a deficiency of \$956 million or 18.7% of total 1984 year-end stated reserves is indicated.

Measures of Adequacy

The most reliable measure of reserve adequacy is the "Run-Off Test". This test takes a retrospective view of reserve levels of prior years and applies against those estimates all subsequent related payments and revised reserve judgments. If a surplus of prior reserve over related subsequent events exists, then prior years' reserves are judged to be excessive. If a deficiency results, then prior years' reserves have proven to be inadequate. (Refer to Appendix V for regulatory "run-off test form").

The obvious shortcoming of this measure of adequacy is that it is strictly retrospective in nature. Any prospective test judging the adequacy of current reserve levels must be subjective in nature.

Regulators do not look to any specific test of reserve adequacy but rather form an opinion based on:

- (i) results of previous year's run-off tests
- (ii) margin of capital and surplus to cover potential undetected errors in the current reserve levels. The Federal Insurance Act specifies in Section 103 that sufficient capital and surplus must be maintained to cover a 15% potential error in all stated reserves.
- (iii) an actuarial report presenting an opinion of the reserve levels. It is apparent that regulators are relying on this opinion more than ever before.

H/ VARIABILITY OF RESERVING PROCEDURES AMONG COMPANIES

The industry-wide data used in Section G above reflects the position of the industry in total.

In an effort to illustrate the wide deviation of reserving methodologies and patterns between lines of business and companies, the graphs shown in Appendix II were created.

Appendix II (Commercial Liability)

- Y axis - Claims Reserves expressed as a % of Premiums Earned (by line of business) was used as a reserve indicator.
- X axis - 34 points each representing one company-year
- 5 data lines - the reserve indicator for each company/year was sorted in ascending order by year.
- Source: 1985 TRAC Report (Exhibit 9)
Canadian Companies with at least \$2,000,000 in reserves for each year 1980-84.

Conclusions:

- (i) Commercial liability reserves have a wide range of levels among companies. In any one year the ratio of reserves to premiums may be in a minimum/maximum range of 100%- 500%.
- (ii) The range has increased markedly in the years 1984 and 1985.
- (iii) Years 1980 and 1981 were reasonably stable in terms of this ratio. In 1982 there appears to have been a slight relaxation of reserve standards relative to premium levels. Years 1983 and 1984 show a very marked strengthening of reserves relative to premium levels.

Appendix II (Property)

This graph is identical to Appendix IIA in every way except that Property reserve indicators are shown instead of Liability.

Conclusions:

- (i) No identifiable trend of reserve strengthening or weakening is evident.
- (ii) For most companies property reserve levels have increased/decreased at the same rate as premium levels.
- (iii) Property reserves show a greater stability not only from one year to the next but also from one company to the other than is evident in commercial liability.

Table II below presents summarized data supporting these conclusions.

Table II
Variability of Reserving Methods
By Line and By Company
Summary

	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>
<u>COMMERCIAL LIABILITY</u>					
# of Companies in Survey	34	34	34	34	34
Industry Average Indicator	190	165	204	264	288
Standard Deviation of Individual Company Indicators	73	61	64	106	111
<u>PROPERTY</u>					
# of Companies in Survey	45	45	45	45	45
<u>Industry Average Indicators (%)</u>	40	38	36	34	36
Standard Deviation of Individual Company Indicators	14	13	17	15	16

I/ DISCOUNTING OF CLAIMS RESERVES

It is the practice of the property/casualty industry to determine claims reserves on an ultimate value basis (i.e., without any regard for the time value of money). To date both insurance regulators and tax officials have accepted this practice.

However there can be no denying that claims reserves calculated on an ultimate basis do possess a "hidden equity".

For the purposes of this report this "equity" shall be defined as the difference between the reserves as stated and the present value of the "actuarially indicated adequate reserves".

Appendix IV presents the technical calculations used in quantifying this "equity" for the all industry data used in Section G above.

For convenience the pertinent assumptions and conclusions are presented below.

1) Assumed Future Payout Stream

First 12 months 51% of ultimate claims are paid
 Next 12 months 24% of ultimate claims are paid
 Next 12 months 6% of ultimate claims are paid
 Next 12 months 4.3% of ultimate claims are paid
 Next 12 months 3.4% of ultimate claims are paid
 Next 12 months 3.1% of ultimate claims are paid
 Next 12 months 2.7% of ultimate claims are paid
 Next 12 months 2.3% of ultimate claims are paid
 Next 12 months *3.8% of ultimate claims are paid

* Factor of 3.8% is compound effect of continuing payments at a decreasing rate for 2-3 subsequent years. This calculation forces the payout to stop at 108 months.

2) Interest Rates

Results for rates of 8%, 10% and 12% are provided. The "least risky" interest rate would be that which results from purchasing fixed income instruments on a maturity schedule matching the payment rate assumed in 1) above.

This matching provides immunization against reinvestment risk yet provides sufficient liquidity for normal operations. It is assumed that this "least risky" rate would lie in the range of 8%-12%.



SEPTEMBER 1985

RECOMMENDATIONS FOR
PROPERTY-CASUALTY INSURANCE COMPANY
FINANCIAL REPORTING

(APPROVED BY COUNCIL ON SEPTEMBER 12, 1985
FOR A TRIAL PERIOD OF ONE YEAR)

PART ONE

INTRODUCTION

1.01 Institute Objectives

Because it is desirable that actuarial information determined by a member for an insurance company's financial reporting

- a. be properly determined and
- b. be fully and clearly disclosed, with no withholding of material informations, favourable or unfavourable,
and because it is desirable that the determination and disclosure
- c. be in a form which permits the member's peers, if his conduct has been challenged, to make a judgment as to whether his conduct was in accordance with good actuarial practice; and
- d. merit the respect of, and acceptance by the public and Superintendents of Insurance;

the Council of the Canadian Institute of Actuaries has approved the following Recommendations for conduct as valuation actuary of a property-casualty insurance company.

1.02 Definitions

CASE RESERVE

For a well define group of claims is the sum of estimates that have been placed on individual reported claims.

CIA RECOMMENDATIONS

Means these recommendations.

CLAIMS ADJUSTMENT EXPENSE RESERVE

Is the estimated amount needed to cover all future expenses required to investigate and settle claims incurred during a particular period. These expenses include internal and external claims adjustment expenses.

CLAIMS ADJUSTMENT EXPENSES

Are all expenses incurred in connection with the settlement of claims. This includes all external expenses incurred in the handling of claims as well as all internal claims expenses.

Internal expenses include all direct expenses of the claim department and any part of the general administration expenses assignable to the claim function.

CLAIMS LIABILITIES

Is the estimated amount which must be paid after the valuation date to settle all claims reported and unreported, (including all adjustment expenses), which have occurred before the valuation date.

DEVELOPMENT

Development is defined as the difference, on successive valuation dates, between observed values of certain fundamental quantities which may be used in the claims reserve estimation process.

GOVERNMENT STATEMENT

Means the annual financial statement required to be deposited with the Superintendent of Insurance.

INCURRED BUT NOT REPORTED CLAIMS RESERVE (IBNR)

This is the reserve for claims incurred but not yet reported to the Company. This reserve also includes claims that have been reported but not yet recorded.

POLICY LIABILITIES

Is the estimated amount which must be paid after the valuation date to service those policies in force as of the valuation date, including the settlement of future claims arising therefrom.

PROPERTY CASUALTY INSURANCE COMPANIES

Those companies required to file form INS 52, INS 53 or their provincial equivalents.

PROVISION FOR DEVELOPMENT ON REPORTED CLAIMS

Is the provision necessary to compensate for the anticipated inadequacy or redundancy in case reserve.

SUPERINTENDENT OF INSURANCE

Means the federal or provincial Superintendent of Insurance having responsibility for administration of the Act under which the company is registered.

TABULAR RESERVES

Individual claims reserves valued using a mortality/morbidity table.

VALUATION DATE

Is the date as of which the reserves are evaluated.

1.03 Conformity with Recommendations

The member should conform to the CIA Recommendations, except in unforeseen circumstances which make them inappropriate. In those circumstances, he should consult with the Committee on Property-Casualty Insurance as soon as is reasonably possible.

Pending advice from the Committee, he should adapt the Recommendations to the circumstances and, when giving his opinion in accordance with Part 7, may regard the valuation as conforming to the Recommendations. The Committee should propose an appropriate change to the Recommendations if it agrees with the member that they are inappropriate. Pending action on that proposal by the Institute, a member who conforms with it is not thereby in breach of these Recommendations if his conduct is in accordance with good actuarial practice.

The Committee may, upon request, advise a member about the application of the CIA Recommendations.

1.04 Changes

These CIA Recommendations reflect the present state of actuarial practice and the insurance business. Institute policy is to change the Recommendations from time to time to take account of advances in actuarial science, and the evolution of the insurance business. To that end, the Committee should actively seek changes in the Recommendations and propose them to council.

1.05 Explanatory Notes

The Committee on Property-Casualty Insurance may distribute Explanatory Notes to the membership.

An Explanatory Note should amplify the CIA Recommendations or illustrate their application, but is not as such binding on any member.

1.06 Documentation

The member may be called upon to justify his work. He should therefore compile and retain documentation which enables him to show that he has conformed to the CIA Recommendations.

1.07 Approximations

An approximation to an assumption or method is acceptable where it reduces the cost of, or improves the member's control over, the valuation, but does not materially affect the result.

1.08 Materiality

A difference is material if it is significant to a user of the financial statements. The member should choose a standard of materiality which will reasonably satisfy each normal user of the financial statements.

PART TWO

DATA

2.01 Introduction

The member should be familiar with the procedures for the administration and accounting of the company's claims and policies.

The member should be conversant with the general characteristics of the insurance portfolio for which reserves are to be established. This would normally include familiarity with the contractual guarantees and obligations under policies in force as well as other attributes, such as deductibles, policy limits and reinsurance provisions, which may have a bearing on reserving.

For the evaluation of policy liabilities, the member should have information about the nature and timing of recent rate changes and the allocation of expenses by categories and lines of business.

2.02 Data Availability and Reliability

It is the member's responsibility to assure that the necessary data for the establishment of proper liabilities are available.

2.03 Reconciliation With Other Data

The member should verify the consistency of the valuation data with the company financial records.

PART THREE

CONSIDERATIONS FOR CLAIM LIABILITIES

3.01 Introduction

Claim reserving is fundamentally concerned with the estimate of ultimate loss and adjustment costs on unpaid claims.

Understanding the trends and changes affecting the data base is a prerequisite to the application of actuarially sound reserving methods. A knowledge of changes in underwriting, claims handling, data processing and accounting, as well as changes in the legal and social environment affecting the experience is essential to the accurate interpretation and evaluation of observed data and the choice of reserving methods.

The establishment and evaluation of proper claim provisions is considerably improved by subdividing the entire claims experience into well defined groups. Where possible, loss data which have been relatively unaffected by changes in company procedures and operations should be used. The possibility of subdividing or combining the data so as to increase its homogeneity or to minimize the distorting effects of underlying or procedural changes on the data should be fully explored.

3.02 Homogeneity

The member should strive to group together those claims exhibiting similar characteristics, such as comparable claim experience patterns, settlement patterns or size of loss distributions. For example, to the extent that the member is dealing with a heterogeneous product, such as commercial multi-peril or miscellaneous liability insurance, consideration should be given to breaking apart these products into more homogeneous groupings. Some other examples of specific considerations regarding homogeneity are the distinction between personal and commercial risks and the distinction between primary and excess coverage.

3.03 Credibility

The degree to which consideration is given to homogeneity is related to the consideration of credibility. Reliability is increased by proper homogeneous groupings on the one hand and by increasing the number of claims analyzed within each group on the other. Obtaining homogeneous groupings requires refinement and fragmentation of the total data base. Clearly, there is a point at which refinement scatters data into cells too small to provide reliable development patterns. Each situation requires a fresh balancing of the considerations of homogeneity and statistical reliability. Thus, line and coverage definitions suitable for the establishment of reserves in large companies can be in much finer detail than in the case of small companies. Where a very small group of claims is involved, use of external information such as industry aggregates may be necessary.

3.04 Emergence Patterns

The delay between the occurrence of claims and the recording of claims on the books of the company depends upon both the line of business and company practices. In general, property claims are reported quickly, whereas the reporting of liability claims may be substantially delayed. The member should continually review the claims handling procedure. Whenever a change in claims handling and recording procedures can be identified, experience should be adjusted to align it with the most recent practice.

3.05 Settlement Patterns

The length of time that it normally takes for claims to be settled will affect the choice of the loss reserving procedure. Claims arising under glass coverage, for example, tend to be settled quickly. On the other hand, bodily injury liability claims often require a long time to settle, even when reported immediately to the company. The ultimate amount of settlement depends on the interaction of more complex variables, such as the type and severity of the damage and the intricacies of the judicial process.

3.06 Development Patterns

The actuary often uses case reserves established by the claim department as a starting point in evaluating total claims liabilities. Therefore, substantial care should be given to reviewing the pattern of development on known cases. The company's claims handling procedures will affect the manner in which the case reserves change over time for any individual claim. Further, the length of time to settlement will affect the observed reserve development.

3.07 Frequency and Severity

The same total dollars of losses may arise from a few large claims or from many small claims. Claim liability estimates will tend to be more accurate for losses resulting from a high frequency/low severity group of claims than from a low frequency/high severity group of claims. Therefore much more care should be taken in analyzing low frequency/high severity groups of claims.

3.08 Reopened Claims Potential

The propensity for claims, which were recorded as closed, to reopen varies substantially among lines of business. Beyond this, precedent-setting judicial opinions and liberalizing legislation can affect the reopening of claims. Company procedures will also affect the potential for claims to be reopened. A time to be alert is when operating procedures (claims, data processing, accounting, etc.) are changing or emphasis is shifting.

3.09 Aggregate Limits

For certain insurance coverages, such as products and malpractice liability, aggregate policy limits will act to restrict total potential incurred losses and therefore claim liabilities. In reviewing groups of claims where aggregate limits apply, audit tests of the data will reveal to what extent limit ceilings have been reached, and in what respect reserve projections may have to be modified to take this factor into account. Proper attention should be paid to defence cost which in many instances will not be limited by the aggregate limit.

3.10 Collateral Sources

For a proper evaluation of a company's total claim liabilities, the impact of salvage and subrogation on the group of claims under consideration should be included. In addition, the impact of coinsurance, deductibles, coordination of benefits, as well as any other collateral sources should be considered.

3.11 Reinsurance Cession

The member should know and consider the types of reinsurance plans and retentions currently in force. To the extent that current arrangements might differ from plans in effect during the claim experience period, the member should estimate the effect such differences might have on observed emergence and development patterns. Consideration should be given to the recoverability of money under reinsurance arrangements.

3.12 Pools and Associations

The total claim liabilities within an insurance company depends in some degree on forces beyond its control, such as business assumed or business obtained through participation in both voluntary and non-voluntary underwriting pools and associations. Nevertheless the member should be aware that the operating and reserving policies and loss development patterns of such business may be different from the insurer's own operation.

3.13 Operational Changes

It is the member's responsibility to review the existing business practices and to verify the continued applicability of past assumptions. the installation of a new computer system, and accounting change, a reorganization of claims responsibility or a change in an underwriting program in a company can affect the continuity of the loss experience. When such changes are observable and the effects are measurable, appropriate compensating adjustments should be made in the procedures for evaluating liabilities.

3.14 Changes in Loss Distribution

Losses may occur in all size ranges. Changes in contract provisions may limit or change the amount of actual claim against the insurance

company through the use of deductibles, policy limits or the sale of excess coverage which excludes all of the primary layer of losses. Such contractual changes affect both the frequency and severity of actual claims. If the change has been occurring over time, such as in the case of a higher deductible being sold for a particular class of policies, attempts should be made to adjust past experience to reflect current circumstances.

3.15 External Influences

Due regard should be given to the impact of external influences. Specific considerations include the judicial environment, regulatory and legislative changes, residual or involuntary market mechanisms, and economic variables such as inflation.

It is not sufficient for the member merely to apply historical analytical procedures in the calculation of reserves. Whenever the impact of internal or external changes on claim data can be isolated or reasonably quantified, adjustment of the data is warranted before applying various reserving methods. Whenever possible, the assumptions underlying each method should be tested statistically. It may be possible to adjust historical data so that the underlying assumptions are more nearly satisfied.

3.16 Claim Reserving Techniques

The two principal strategies usually employed are the report period approach and the accident period approach. When a report period approach is used, an attempt is made to measure the upward or downward development on claims which have already been reported to the company and to use that measurement to estimate the aggregate reserve redundancy or deficiency on those claims. To determine IBNR, additional analysis by accident period is required in order to measure the emergence of IBNR.

When a pure accident period approach is used, report dates are ignored and an attempt is made to estimate directly the ultimate cost of all claims, whether reported or not, arising from accident periods prior to the valuation date. This approach results in an estimate of the total claim liability. The total claim liability is then apportioned between provisions for IBNR and known claims on a suitable basis.

The use of accident period techniques can, under certain circumstances, lead to a seemingly broader definition of IBNR than is used in these recommendations. If, for instance, an accident period approach has been used to estimate directly the total claim liability and IBNR is obtained simply by subtracting the case reserve from the total, the provision for future development on known claims will automatically be included with IBNR. In these circumstances the provision for reopened claims will also be included with IBNR.

Detailed discussion of the technology and applicability of current claim reserving practices is beyond the scope of these

recommendations. Selection of the most appropriate method of reserve estimation is the responsibility of the member. An member will ordinarily examine the indications of more than one method before arriving at an evaluation of an insurer's liability for a specific group of claims.

PART FOUR

CONSIDERATIONS FOR POLICY LIABILITIES

4.01 Introduction

Policy liabilities are the anticipated costs for servicing the unexpired portion of the policies in force. These liabilities include a provision for future claims and a provision for future expenses.

4.02 Annual Statement Treatment

Policy liabilities are not shown explicitly on the annual statement but are the net total of the unearned premium reserve, deferred acquisition expenses and/or premium deficiency. The member should determine policy liabilities in total and the unearned premium.

If the policy liabilities are less than the unearned premium, the difference should be shown as Deferred Acquisition Expenses. However, the Deferred Acquisition Expenses should not be greater than the "unearned" portion of acquisition expenses.

If the policy liabilities are greater than the unearned premium the difference should be shown as a premium deficiency.

4.03 Premium Level

The estimated claim ratios of the unexpired policies should be evaluated in light of the results of current and previous years taking into account the changes in average premium level.

4.04 Trend Factors

Appropriate trend factors should be applied to past and current claim ratios in order to evaluate the claim level for the unexpired portion of the policies in force. The trend factors will generally be consistent with those used in the ratemaking process.

4.05 Seasonality of Losses

The nature (frequency and severity) of claims tend to vary according to season. As the unexpired portion of the in force policies has a much heavier exposure in the first half of the coming year, such effect has to be evaluated.

PART FIVE

METHODS AND ASSUMPTIONS

5.01 Appropriateness

Each method and assumption should be appropriate to the circumstances of the company and the policies in force.

5.02 Change in Assumptions

The member should choose methods and assumptions which are appropriate at the valuation date, except that he need not change from those of the prior valuation unless the effect of the change is material. The member's standard of materiality should be more rigorous for a change which increases liabilities and less rigorous for a change which decreases them.

The member should not spread the effect of a change in method or assumption over more than one valuation.

5.03 Disclosure of Effect of Change

Where (i) the methods or assumptions differ from those in the prior valuation and (ii) the difference is material at the current and prior valuation dates then the effect of the change on the current accounting statements shall be disclosed.

5.04 Provision for Adverse Deviations

It is not possible to determine total liabilities with complete confidence. In evaluating liabilities, consideration should be given to the insurer's responsibilities to policyholders and claimants, as well as the inherent variability of conditions affecting future claim payments.

Such consideration will result in the estimation of liabilities on a conservative basis. The degree of conservatism is a matter of actuarial judgment and depends upon the following factors:

1. the member's confidence in the expected development pattern.
2. the time period over which the liabilities will extend.
3. the statistical fluctuations affecting claims development and reporting pattern.
4. the quality and depth of historical data on the basis of which the reserve liabilities is evaluated.

Provision for adverse deviation needs not to be explicit; estimates may be conservative due to the member's selection of methodology and assumptions.

The member should not make provision in the liabilities for abnormal adverse deviations.

5.05 Discounting Claim Liabilities

When establishing provisions, the following guidelines should be used concerning the discounting of claim liabilities:

- a. claims are not customarily discounted for anticipated investment earnings between the date of claim and the date of settlement, except for tabular reserves.
- b. short term claims and long term uncertain amount claims may be discounted in the aggregate provided the impact is material and sufficient provision for adverse deviation has otherwise been included.
- c. where provisions are discounted the undiscounted provision shall also be calculated for the purpose of testing runoff patterns.

5.06 Investment Return

When discounting provisions, the member should base his investment return on what he expects the portfolio to earn net of investment expenses.

The following factors should be considered:

1. methods of reporting investment income and of valuing assets in the annual statement.
2. allocation of investment income to surplus and among lines of business and years of investment.
3. the earnings of the current portfolio.

5.07 Reasonableness

The member has a responsibility to consider the reasonableness of the indications produced by the evaluation procedures employed. The incurred losses implied by the provisions should be measured against relevant parameters, such as premium, exposures or number of policies, and expressed wherever possible in terms of frequencies, severities and loss ratios. No material departure from past results should be accepted without attempting to find an explanation for the variation.

THE ACTUARY'S REPORT IN
PUBLISHED FINANCIAL STATEMENTS

6.01 Application

This part applies where a statement of the Property-Casualty valuation actuary's opinion is included in the annual financial statements for:

- a. the global operations of a Canadian insurance company registered under the Canadian and British Insurance Companies Act;
- b. the global operations of a Canadian insurance company registered under a provincial statute designated by Council; or
- c. the Canadian operations of a British insurance company registered under the Canadian and British Insurance Companies Act, or of a foreign insurance company registered under the Foreign Insurance Companies Act, where a balance sheet is included;

and are presented at its annual meeting in Canada or intended for the information of the Canadian shareholders, policyholders, or general public.

6.02 Text of the Report

The following is recommended for the financial statements of an insurance company which included an income statement and which do not involve consolidation of a foreign subsidiary:

REPORT OF THE PROPERTY-CASUALTY VALUATION ACTUARY

I have made the valuation of the policy and claims liabilities of the XYZ Insurance Company for its balance sheet at 31 December 19 and its income statement for the year then ended. In my opinion (i) the valuation conforms to the Recommendations for Property-Casualty Insurance Company Financial Reporting of the Canadian Institute of Actuaries, (ii) the amount of the policy and claims liabilities makes proper provision for the future payments under the company's policies, (iii) a proper charge on account of those liabilities has been made in the income statement.

The member should delete the references to income statement where the financial statements do not include one. The member should adapt the highlighted words to his situation but make no other change.

Where there is a consolidated foreign insurance subsidiary, the member should adapt the following model to his situation:

REPORT OF THE VALUATION ACTUARY

I have made the valuation of the policy and claims liabilities of the Parent Insurance Company for its consolidated balance sheet at 31 December 19 and its consolidated income statement for the year then ended. In my opinion, the valuation for Parent Insurance Company conforms to the Recommendations for Property-Casualty Insurance Company Financial Reporting of the Canadian Institute of Actuaries. I have relied upon the valuation made by the actuary of the subsidiary company. In my opinion, (i) the amount of the policy and claims liabilities makes proper provision for future payments under the company's policies (ii) a proper charge on account of those liabilities has been made in the consolidated income statement.

6.03 Signing

In signing the opinion, the member should identify his connection with the company. He should identify himself as a Fellow of the Canadian Institute of Actuaries or F.C.I.A.: he may also append other professional qualifications.

6.04 Filing

The member should file a copy of his report with the auditor, where one has been appointed to report on the published financial statements and a copy with the Board of Directors. The filing should set forth the amounts which the member determined.

6.05 Disclosure Notes

The note for a situation in section 6.06 should:

- a. describe the situation,
- b. state its effect on liabilities, surplus, and net income for the current year and each past year reported on in the financial statements, and
- c. indicate its projected future financial effect.

The note should be as short as possible. It should use the ordinary dictionary meaning of words and avoid jargon.

Matters covered by a note which do not lend themselves to an unqualified assertion of fact should be qualified by words like "in the opinion of the Property-Casualty valuation actuary".

6.06 Disclosure Situations

The member should not sign the report unless he has reason to believe that the financial statements will include a note drafted according to section 6.05 and covering each of the following situations which is applicable:

- a. The assumptions or methods differ from those in the prior valuation and (i) the difference applies to policies having material policies and claims liabilities at the prior valuation and (ii) the effect of the difference is material at the valuation or is expected to be material afterwards. The member may use a standard of materiality less rigorous than that used for the purpose of section 5.02.
- b. The member cannot in conscience say that the data are "sufficient and reliable", that the assumptions are "adequate and appropriate", and that the methods are "consistent with sound actuarial principles", as set forth in item 4.(b) of the Guides to Professional Conduct. The member should, however, try to avoid this situation.
- c. Since the prior valuation, the company has taken an action or adopted a practice which materially alters the timing of emergence of income or surplus.
- d. Between the valuation date and the date he signs the report, the member becomes aware of information emerging or an event occurring whose financial implications are themselves material and also materially at variance with the valuation.
- e. The member considers any other aspect of an actuarial nature to be relevant to fair presentation.

6.07 Implications of Report Language

This section considers some of the professional implications of the text in section 6.02.

"I have made the valuation..." The report includes an opinion of an actuarial determination by the member, not an opinion about a review of a determination by another actuary.

The member may delegate a substantial part of the work to other persons who act under his technical supervision. The member, however, takes responsibility for the results and he should have enough control over the work to meet that responsibility.

"Policy and claims liabilities..." In the case of policy liabilities this covers the net of unearned premiums and deferred policy acquisition expenses or premium deficiencies and in the case of claims liabilities unpaid claims and adjustment expenses as used on the annual statement. These items should appear separately on the balance sheet so they can be identified.

The member should not reduce the responsibility taken in his report simply because the auditor in his report is taking responsibility for one or more of the policy and claims liabilities.

"In my opinion..." These words are needed because an actuarial determination does not lend itself to an unqualified assertion of fact. However, the words are a disclosure, not an escape clause. They mean, "I hereby certify that in my considered opinion as a professional actuary..."

"...proper provision..." is more than barely sufficient. It is a good and sufficient provision determined from:

- a. adequate and appropriate assumptions, and methods consistent with sound actuarial principles, as described in these Recommendations and in the actuarial literature, or
- b. where more rigorous, applicable statutory requirements.

"...future payments..." include both amounts incurred before and amounts incurred after the valuation date.

"...proper charge...in the income statement" The charge does not appear as a separate number in the income statement.

PART SEVEN

THE REPORT BY THE PROPERTY-CASUALTY VALUATION ACTUARY IN THE GOVERNMENT STATEMENT

7.01 Application

This part applies where a member prepares the valuation actuary's report for a government statement of:

- a. an insurance company registered under the Canadian and British Insurance Companies Act, or
- b. an insurance company registered under a provincial statute designated by Council.

7.02 Footnoted Reserves

The member should describe his method of establishing these reserves.

7.03 Disclosure Situations

For each of the situations in items a. through e. of section 7.06 the member should

- a. describe the situation,
- b. state its effect on reserve, surplus and net income for the current year and the prior year, and
- c. indicate its projected future financial effect.

7.04 Drafting the Report

Matters in the report which do not lend themselves to an unqualified assertion of fact should be qualified by words like "in my opinion".

The member may use terminology and formulae which will be understood by another actuary, but which need not necessarily be understood by a layman.

When the member uses a term defined in the CIA Recommendations, it is understood to have the same meaning unless he otherwise specifies.

EXPLANATORY NOTE - 3.11 REINSURANCE SESSION

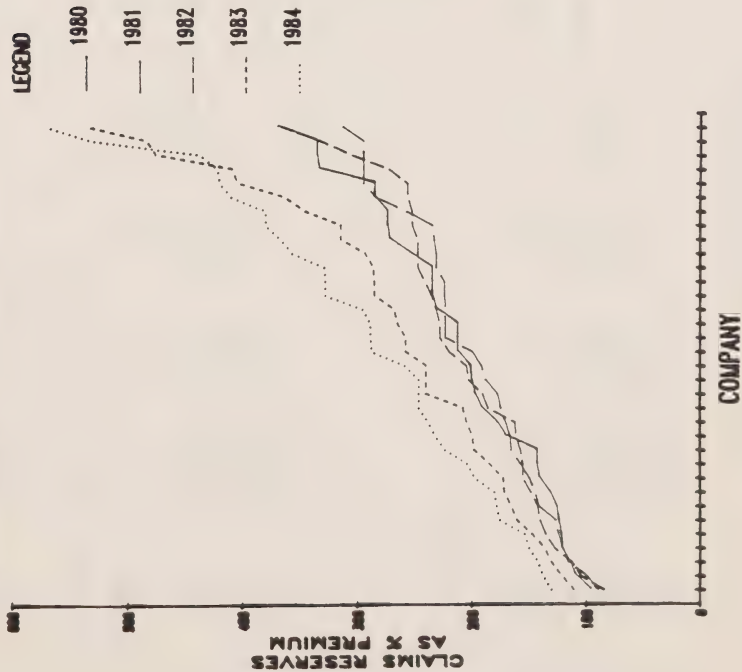
This recommendation calls for familiarity on the part of the member with all reinsurance ceded arrangements which might have an effect on net outstanding claims because of potential recoveries from reinsurers. The last sentence requires that consideration be given to the recoverability of money under any such arrangements.

Due recognition should be given to readily available information which might cast doubt on the financial stability of reinsurers to whom business has been ceded. Nonetheless the scope of the member's responsibility under this section would normally be limited to determining the amount of the net claims liabilities. Detailed assessment of the financial condition of all companies to whom reinsurance has been ceded would be beyond the scope of the actuary's responsibility.

COMMERCIAL LIABILITY

RESERVE VARIABILITY

AMONG 34 CANADIAN COMPANIES

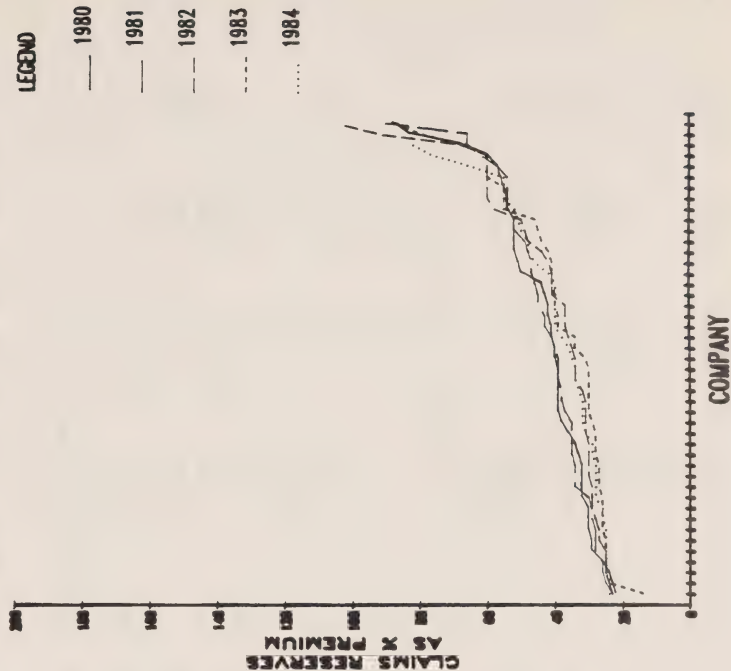


THE WYLLIE COMPANY

PROPERTY

RESERVE VARIABILITY

AMONG 45 CANADIAN COMPANIES



THE WYLLIE COMPANY

CLAIMS DEVELOPMENT

DEVELOPMENT FACTORS

NET CLAIMS OUTSTANDING (\$000)

ACCIDENT YEAR	12 MOS	24 MOS	36 MOS	48 MOS	60 MOS
1980	1,753,514	735,069	512,494	440,255	390,873
1981	2,003,569	820,844	650,811	531,804	
1982	1,950,302	936,300	750,577		
1983	2,145,516	1,035,812			
1984	2,490,483				

NET CLAIMS PAID (\$000)

NET CLAIMS PAID

ACCIDENT YEAR	12 MOS	24 MOS	36 MOS	48 MOS	60 MOS	ACCIDENT YEAR	24:12	36:24	48:36	60:48
1980	1,995,238	3,006,504	3,261,348	3,431,634	3,568,133	1980	1.507	1.085	1.052	1.040
1981	2,334,630	3,470,531	3,730,485	3,949,400		1981	1.407	1.077	1.056	
1982	2,542,029	3,532,563	3,822,149			1982	1.389	1.082		
1983	2,306,427	3,402,935				1983	1.475			
1984	2,646,256					1984				
						MEAN	1.465	1.081	1.054	1.040

NET CLAIMS INCURRED (\$000)

NET CLAIMS INCURRED

ACCIDENT YEAR	12 MOS	24 MOS	36 MOS	48 MOS	60 MOS	ACCIDENT YEAR	24:12	36:24	48:36	60:48
1980	3,740,752	3,741,593	3,773,842	3,831,889	3,869,006	1980	0.990	1.009	1.015	1.010
1981	4,330,199	4,291,375	4,389,296	4,481,204		1981	0.989	1.023	1.021	
1982	4,493,131	4,460,943	4,572,726			1982	0.995	1.023		
1983	4,451,943	4,430,747				1983	0.997			
1984	5,136,739					1984				
						MEAN	0.995	1.018	1.018	1.010

* SOURCE: FEDERAL DEPARTMENT OF INSURANCE

Review of Adequacy of Industry Reserve LevelsAll Canada (Federal Companies)/All Lines

(Refer to Appendix III for background detail)

Estimate of Ultimate Claims Amounts (000)

Accident Year	<u>Incurred Method</u>		<u>Paid Method</u>	
	<u>Factor</u>	<u>Estimated Ultimate Cost</u>	<u>Factor</u>	<u>Estimated Ultimate Cost</u>
1980	1.00	\$ 3,869,006	1.14	\$ 4,067,672
1981	1.01	4,889,616	1.18	4,660,292
1982	1.028	4,700,762	1.25	4,777,686
1983	1.047	4,647,368	1.35	4,593,962
1984	1.041	5,347,345	1.97	5,213,124
Total Estimate		\$23,454,097	\$23,312,736	
Total Accounted For		22,498,422	22,498,422	
- Reserve Excess (Deficiency)		(955,675)	(814,314)	
- Excess (Deficiency) as % of Stated Reserves		(18.7%)	(15.9%)	

ALL CANADA-ALL LINES
FEDERALLY REGISTERED PROPERTY/CASUALTY INSURERS
ASSESSMENT OF DISCOUNTED RESERVES
AT DECEMBER 31, 1984

LINE OF BUSINESS	PAYMENT RATE-MATURITY POINT (MONTHS)											
	12	24	36	48	60	72	84	96	108			

ALL LINES-ALL FEDERAL COMPANIES	DEV'T FAC	1	1.465	1.001	1.054	1.04	1.035	1.03	1.025	1.04		
	CLM'VE	1	1.465	1.58365	1.669182	1.735950	1.796708	1.850699	1.898874	1.972749		
	PAYMENT	1	0.465	0.118665	0.085517	0.068758	0.053591	0.042865	0.035874			
	SUM		0.972749	0.507749	0.389084	0.303567	0.236799	0.178041	0.122140	0.075874		

YEAR	MATURITY LEVEL	RESERVES	1986	1987	1988	1989	1990	1991	1992	1993	TOTAL
1980	60	300873	77190	68486	58784	96405	0	0	0	0	300873
1981	48	940216	206794	180182	166944	143294	235002	0	0	0	940216
1982	36	878613	193112	150771	137201	121717	104474	171337	0	0	878613
1983	24	1244433	290833	209594	163639	140911	132105	113390	185960	0	1244433
1984	12	2701089	1291191	329504	237462	185397	168711	149671	128467	210606	2701089
			6065224	2069129	946536	695724	640292	434398	314428	210606	6065224

PRESENT VALUE FACTORS		0.5	1.5	2.5	3.5	4.5	5.5	6.5	7.5
	8%	0.962250	0.890972	0.824974	0.763065	0.707282	0.654891	0.606381	0.561463
	10%	0.953462	0.866784	0.787905	0.716350	0.651227	0.592025	0.538204	0.489277
	12%	0.944911	0.843670	0.753277	0.672569	0.600508	0.536167	0.478721	0.427429

DISCOUNTED RESERVES	8%	5832708	1901398	843330	630306	531439	452068	284484	194663	118293
	10%	4830634	1963382	820443	602045	498302	416976	257175	169226	103084
	12%	4645696	1945694	798565	575527	467922	384501	232910	150523	90054

AMOUNT OF DISCOUNT	-8%	1832436
	-10%	1234590
	-12%	1419528

EXHIBIT 34 - NET CLAIMS AND ADJUSTMENT EXPENSES - TOTAL
REVIEW OF CLAIMS SETTLEMENTS AND UNPAID AMOUNTS REPORTED IN PREVIOUS ANNUAL STATEMENTS

(a)	19 and prior year (02)	19 (03)	19 and prior (02) + (03) (04)	19 (05)	19 and prior (04) + (05) (06)	19 (07)	19 and prior (06) + (07) (08)	19 (09)	19 and prior (08) + (09) (10)	19 (11)	19 and prior (10) + (11) (12)
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Unpaid amounts, Dec. 19	01										
Paid during 19	02										
Unpaid amounts, Dec. 19	03										
Excess or (Deficiency)	04										
Ratio	05										
Paid during 19	06										
Unpaid amounts, Dec. 19	07										
Excess or (Deficiency)	08										
Ratio	09										
Paid during 19	10										
Unpaid amounts, Dec. 19	11										
Excess or (Deficiency)	12										
Ratio	13										
Paid during 19	14										
Unpaid amounts, Dec. 19	15										
Excess or (Deficiency)	16										
Ratio	17										
Paid during 19	18										
Unpaid amounts, Dec. 19	19										
Excess or (Deficiency)	20										
Ratio	21										
(Lines 18 + 19) 22											(b)
Total											(c)

Excess or Deficiency: Operating unpaid amounts as shown at head of column less total amounts paid to excess or deficiency date less unpaid amounts at excess or deficiency date
Ratio: Excess or deficiency divided by unpaid amounts at the head of the column.

(a) Including a total of \$'000 _____ for incurred but not reported claims, allocated as follows: (25) 19 ____: \$ _____ (current year) 19 ____: \$ _____ (1st prior year)
(26) 19 ____: \$ _____ (2nd prior year) 19 ____: \$ _____ (3rd prior year)
(27) 19 ____: \$ _____ (4th prior year) 19 ____: \$ _____ (5th and all prior years)

(b) Deduct unpaid amount for previous year, line 15, column 10

(c) This total should include the amount shown on line 15, column 01, Exhibit 43, Adjustment Expenses and should be the same as that amount shown on line 08, column 01, Exhibit 3, Statement of Income.

APPENDIX 9

Task Force on the Insurance Industry

Ontario and Canada:

Overview of the Regulation of Insurance

April, 1986

M. Elizabeth Atcheson
Cassels, Brock & Blackwell

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INTRODUCTION

The purpose of this paper is to identify the principal features of Canadian and Ontario laws governing insurance. Looking back over a century of regulation, one is struck by the dearth of published materials analyzing the policies behind the provisions and the provisions themselves in operation. Innovation has been rare: change has occurred gradually and, to some degree, sparingly. The principal features of the regulatory scheme were established early in the century and have weathered the turbulence resulting from pressures and changes caused by competition and consumer demand.

The history of statutory amendments suggests that insurance regulation has been highly reactive to changes in the marketplace and, more specifically, to abuses in the market place. The regulation would appear to have been less interventionist than many might think.

Insurance corporations, while they have not to date had the legal status of natural persons, nonetheless have had considerable range in which to execute their objects. The statutes illustrate overriding concern with stability, solvency and the results of unequal bargaining power amongst contracting parties. Most significant changes touched on these matters. Apart from automobile insurance, however, there is very little rule-making associated with developments in the design of products or the terms of availability of such products, particularly with respect to property-casualty insurance products. For these reasons, it is difficult (if not impossible) to track changes in the insurance marketplace with changes in insurance regulation.

In fact, there appears to have been a long-standing aversion to detailed rule-making (including enforcement procedures), even with respect to stability and solvency matters. In the regulatory context, that choice is like a sword which cuts both ways. It gives the regulator wide, de facto power to deal with a known problem company through a combination of negotiation and direction (a form of "moral suasion"). In the case where a problem is either difficult to detect or (on the other extreme) systemic, the Superintendent's de jure remedial powers may be cumbersome (because of built-in procedural safeguards for the affected party) or inadequate.

To some extent, the debate about breaking down the separate identities of the "four pillars" has obscured critical regulatory questions about how to predict and control negative change (eg. insolvencies) while facilitating positive change (eg. networking). These questions, however, would be on the public agenda even if the current capacity and cost cycle in the property-casualty industry were not occurring.

The rate of change in the regulatory system generally has simply not met the rate of change (negative and positive) in the industry, with resulting disequilibrium. The current proposals for amendment (Bill 108 in Ontario and the federal Superintendent's of Insurance memorandum) are remedial and continue the tradition of limited "patch-work" (albeit needed) amendments. There does not appear to be a consensus (looking at the Dupre Report and the Blenkarn Report, in particular) on either an overhaul of the regulatory system or on fundamental features of corporate governance. There is no question that a complicating factor is the split constitutional jurisdiction over insurance matters, as well as the international nature of the industry (and particularly the property-casualty industry).

The record shows that we are not in a period of significant regulatory change where we can identify and measure successes and failures. While many strains on property-casualty insurers are unrelated to questions of regulation and governance, public confidence in the regulatory system is a critical, perhaps intangible factor in public confidence in property-casualty insurers.

1.0 THE CONSTITUTIONAL FRAMEWORK

1.1 Power to Incorporate Domestic Companies

1.1.1 The Constitution Act, 1867 (30 and 31 Victoria, c.3, as amended by the Constitution Act, 1982, Schedule B to the Canada Act 1982 (U.K.) 1982, c.11) which governs the distribution of powers between the federal and provincial governments, provides:

92. In each Province the Legislature may exclusively make Laws in relation to Matters coming within the Classes of subject next hereinafter enumerated; that is to say,--...
11. The Incorporation of Companies with Provincial Objects....

1.1.2 The Act, however, does not contain a similar power for Parliament, with the result that the federal power to incorporate has been held by the courts to derive from the residual power of Parliament as follows:

91. It shall be lawful for the Queen, by and with the Advice and Consent of the Senate and the House of Commons, to make Laws for the Peace, Order and good Government of Canada, in relation to all Matters not coming within the Classes of Subject by this Act assigned exclusively to the Legislatures of the Province...

See: Citizens Insurance Co. v. Parsons (1881), 7 A.C. 96, at pp. 116-117, per Smith, J. (J.C.P.C.).

1.1.3 It is necessary to determine when a company is incorporated for "provincial objects". On the one hand, it is clear that a federal company may exercise its powers in one province only so long as the company was incorporated with powers to carry out business across Canada (The Colonial Building and Investment Association v. The Attorney-General of Quebec (1883), 9 A.C. 157). On the other hand, a provincial company also may carry on business outside the province in which it was incorporated. The courts have held that a provincial corporation has the capacity to accept extra-provincial powers and rights unless its charter provides otherwise (Bonanza Creek Gold Mining Company, Limited v. The King et al. (1916), 1 A.C. 566 (at pp. 583-84, per Haldane, J. (J.C.P.C.)).

1.2 Power to Licence Foreign Companies

Parliament has power under section 91 (under the heads of power pertaining to trade and commerce - 91(2) - and aliens - 91(25)) of the Constitution Act, 1867 to require a foreign company to obtain a licence from federal authorities. Again, this is so whether the foreign company will be operating in a single province only. See: Attorney-General for Canada v. Attorney-General of Alberta and Attorney-General of British Columbia (1916), 26 D.L.R. 288, at p. 291 per Haldane, J.C.P.C.).

1.3 Power to Regulate the Business of Insurance

1.3.1 Neither section 91 and 92 of the Constitution Act, 1867 refer specifically to insurance or contracts of insurance.

1.3.2 The courts consistently have held that the regulation of the business of insurance, including contracts of insurance, is solely within the jurisdiction of the provinces under subsection 92(13), "Property and Civil Rights in the Province". See: Attorney-General for Ontario and Reciprocal Insurers and Others [1924] A.C. 328, at p. 346 per Duff, J..

1.4 Federal-Provincial Relationships

The disputes about the powers of the two levels of government with respect to the regulation of insurance entities and business spanned a period of decades early in this century. In 1931, one member of the Judicial Committee of the Privy Council, Viscount Dunedin, remarked in frustration: "This case is, it may be hoped, the last of the series of litigations between the Dominion and the provinces with regard to insurance". (Attorney-General for Quebec v. Attorney-General for Canada [1932], 1 D.L.R. 97, at p. 100).

In 1917, provincial Superintendents formed "The Association of Provincial Superintendents of Insurance of the Dominion of Canada" as a forum to discuss ways and means to secure uniformity in the laws relating to contracts of insurance. In more recent years, the federal Superintendent of Insurance has participated in the Association, joining it officially only in 1985. It is now known as the "Canadian Council of Superintendents of Insurance".

2.0 REGULATION OF INSURANCE IN ONTARIO: HISTORICAL HIGHLIGHTS

2.1 The business of insurance in Ontario has been subject to regulation by statute for well over a century. The principal features of today's regulation can be identified in the early statutes, several of which were consolidated in The Ontario Insurance Act (60 Vict. c.36, which appeared without change as R.S.O. 1897, c.203).

2.2 The 1897 Act reinforced the established separate identity of insurance corporations by providing that:

54. No insurance other than as enacted by and for the purposes of The Land Titles Act, and any other contracts of guarantee undertaken by a company standing registered under The Loan Corporations Act, shall be transacted or undertaken in Ontario except by a corporation duly registered as herein provided...
- 85.- (1) After the 31st day of December, 1892, no person or persons, or body corporate or unincorporated, other than a corporation standing registered under this Act and persons duly authorized by law and by such registered corporation to act in its behalf, shall undertake or effect, or offer to undertake or effect any contract of insurance....

"Insurance" was defined inclusively:

- 1.-41. "Insurance" shall include the following, whether the contract be one of primary insurance, or of reinsurance, and whether the premium payable be a sum certain, or consist of sums uncertain or variable in time, number or amount—
- (a) Insurance against death, sickness, infirmity, casualty, accident, disability, or any change of physical or mental condition;
 - (b) Insurance against financial loss; or against loss of work, employment, practice, custom, wages, rents, profits, income or revenue;
 - (c) Insurance of property against any loss or injury from any cause whatsoever, whether the obligation of the insurer is to indemnify by a money payment, or by restoring or reinstating the property insured;

- (d) Contracts of endowment, assessment-endowment, tontine, semi-tontine, lifetime benefits, annuities on lives, or contracts of investment involving tontine or survivorship principles for the benefit of persisting members; or any contract of investment involving life contingencies;
- (e) Any contract made on consideration of a premium and based on the expectancy of life; or any contract made on such consideration and having for its subject the life, safety, health, fidelity, or insurable interest of any person, whether the benefit under the contract is primarily payable to the assured or to a donee, grantee or assignee, or to trustees, guardians, or representatives, or to (or in trust for) any beneficiary, or to the assured by way of indemnity or insurance against any liability incurred by him by or through the death or injury of any person;
- (f) Any investment contract under which lapses or payments made by discontinuing members or investors, accrue to the benefit of persisting members or investors, except where a corporation (other than an insurance corporation) is expressly authorized to undertake such contract by a statute in force in Ontario;
- (g) Generally any contract in the nature of any of the foregoing whereby the benefit under the contract accrues payable on or after the occurrence of some contingent event.

The 1897 Act governed, for example, the incorporation of joint stock companies (including the minimum capital stock required); the formation and incorporation of mutual and cash-mutual fire insurance companies and friendly societies; the requirement to be licensed and to make a deposit before being registered; the requirement to keep books, to have an annual audit* and to file annual statements; the requirement that each company be inspected periodically and the remedies for deficiencies; the limitation of investments to permissible investments; and, liquidation. The 1897 Act included certain provisions on contracts of insurance, including specific provisions on insurance of the person and fire insurance.

* The audit requirement was removed and replaced by a provision authorizing the Minister to nominate a person to conduct one from time to time. R.S.O. 1927, c.222, s-s 69(2).

2.3 From 1897 on, the Act was amended virtually every year until 1979 and it was restated entirely from time to time. The 1897 Act was repealed and replaced by The Ontario Insurance Act, 1912 (S.O. 1912, c.33). It incorporated (section 15) a 1902 amendment (S.O. 1902, c.12, section 22) which restricted the formation of new municipal fire mutual insurance companies to the situation where it could be shown to the satisfaction of the Minister that a municipality did not have adequate provision for insurance on the mutual plan against fire. It also added a new provision governing brokers' licences for business with unregistered foreign corporations as follows:

- 100.- (1) Where the Minister is of the opinion that insurance or sufficient insurance of property cannot be obtained with registered insurers at ordinary or reasonable rates of premium, he may from time to time by license made for a term not in any case extending beyond the new insuring 30th day of June, authorize an insurance broker... to effect such insurance with insurers approved by the Minister not registered under this Act, and not transacting business in Ontario...

A monthly reporting requirement was imposed on the licensee.

The 1912 Act also made it more difficult for non-Canadian incorporated companies to become licensed in Ontario. Such a company had to prove to the satisfaction of the Minister that it had carried on elsewhere successfully for at least five years the same type of business for which it sought a licence in Ontario (S.O. 1912, c.33, section 65)*. The audit requirement was removed and replaced by a provision authorizing the Minister to nominate a person to conduct one from time to time. R.S.O. 1927, c.222, s-s. 69(2).

Contracts of livestock insurance and weather insurance (previously regulated under separate statutes) were incorporated in separate parts in the 1912 Act.

2.4 Automobile insurance was added in 1914 (R.S.O. 1914, c.183, as amended by S.O. 1914, c.30, section 2 to 4). Agents and underwriters' agencies also were regulated for the first time in 1914 (S.O. 1914, c.30, sections 5 and 6).

* Repealed S.O. 1926, c.49, section 5.

2.5 In 1922, the Act was amended to include detailed provisions on accident insurance and automobile insurance, including statutory conditions (S.O. 1922, c. 61, sections 12 and 14, respectively). A new part was added to the Act governing agents, brokers and adjusters (section 16), as well as one on rates and rating bureaus (section 17). Further, a separate act governing reciprocal or inter-insurance was enacted (S.O. 1922, c.62). It provided that:

3. It shall be lawful for any person to exchange with other persons in Ontario and elsewhere reciprocal contracts of indemnity or inter-insurance for any class of insurance for which an insurance company may be licensed under the provisions of The Ontario Insurance Act except life insurance, accident insurance, sickness insurance and guarantee insurance.

2.6 The Ontario Insurance Act, 1924 (S.O. 1924, c.50) restated the 1914 Act, with amendments, and added some innovations to the regulatory scheme. First, it categorized (subsection 23(1)) the types of insurance companies in the manner still in use. Second, it provided that licences would be granted for classes of insurance, which were listed (subsection 24(1)). Interestingly, the minimum amounts of capital required to be subscribed and paid generally were lowered (subsection 25(1)). Two new parts of the Act were added pertaining to fraternal societies and mutual benefit societies. Overall, the most striking feature of the 1924 Act is the resemblance which it bears to the current legislation. The 1924 Act was reenacted by R.S.O. 1927, c.222, at which point it became known as The Insurance Act.

2.8 Aviation insurance was added as a class of insurance in 1929 (S.O. 1929, c.53, subsection 2(1)).

2.9 The principal revisions in 1930 established the Superintendent's authority to require that the companies carrying on the business of automobile insurance file information on premiums, losses and expenses (S.O. 1930, c.41, section 2). Whereas in 1922 the Act was amended to prohibit discrimination in rates, in 1930 the Superintendent was given power to intervene to adjust rates (section 12):

- 275a.- (1) It shall be the duty of the Superintendent after due notice and a hearing before him, to order an adjustment of the rates for automobile insurance, whenever it is found by him that any such rates are excessive, inadequate, unfairly discriminatory, or otherwise unreasonable.

(2) Any order made under this section shall not take effect for a period of ten days after its date, and shall be subject to appeal within that time by any insured, insurer or rating bureau, in the manner provided by section 12 of this Act and, in the event of an appeal, the order of the Superintendent shall not take effect pending the disposition of the appeal.

(3) The Attorney General shall be served with notice of any such appeal and shall be entitled to be heard by counsel upon the hearing thereof.

(4) Any rating bureau, insurer or other person failing to comply with any provision of such order shall be guilty of an offence.

2.10 In 1932, the automobile part of the Act was repealed and replaced (S.O. 1932, c.25, section 2). Thereafter, amendments were made to the Act on a regular basis and were consolidated in succeeding revisions (R.S.O. 1937, c.256, R.S.O. 1950, c.183 and R.S.O. 1960, c.190).

2.11 In 1947, the government established (S.O. 1947, c.45, s.16) the "Unsatisfied Judgment Fund" under The Highway Traffic Act. Each person licenced to drive in Ontario was required to pay a stipulated amount into the Fund. Individuals who had been awarded damages, arising out of a motor vehicle accident in Ontario by a court in Ontario, but who had been unable to collect the judgment could, on proof of certain matters and subject to monetary limits, recover from the Fund. Individuals to whom loss had been occasioned by an unidentified driver could also recover in certain circumstances. In 1962, a new statutory regime was introduced and the "Motor Vehicle Accident Claims Fund" was created (An Act respecting Claims for Damages Arising out of Motor Vehicle Accidents, S.O. 1961-62, c.84). This Act introduced a new requirement, i.e., each owner of a motor vehicle was required to be able to produce evidence that either a vehicle was insured or the uninsured motor vehicle fee had been paid (section 3). It has subsequently been amended on several occasions, most recently on the introduction of compulsory insurance.

2.12 The Insurance Act was amended in 1970 (S.O. 1970, c.134) in several significant ways. The minimum licence requirements for subscribed and paid-up capital stock were increased dramatically (section 4). The Superintendent was given power to take control of the assets of an insurer where assets could not be

accounted for satisfactorily (section 7). Two new parts on investments and unfair and deceptive business practices were added (section 17). In 1971, Schedule E was added to the Act (S.O. 1971, c.84, section 26), which established mandatory medical and rehabilitation benefits and accident benefits for those injured in an accident out of the use or operation of an automobile.

2.13 In 1972, the Act was amended to prohibit the granting of a licence to a corporation carrying on business as an insurance agent, broker or adjuster if the majority of its issued and outstanding shares were owned (beneficially or otherwise) by non-resident(s) (S.O. 1972, c.66, section 14).

2.14 Major revisions were made to the Act on the introduction of compulsory automobile insurance in 1979 and the self-regulation of brokers in 1980.

3.0 FEDERAL REGULATION: HISTORICAL HIGHLIGHTS

3.1 Although Parliament passed legislation governing insurance companies as early as 1868, disputes over federal constitutional authority, and specific federal legislation, were waged until 1931 (see Section 1.0 above). In 1932, Parliament passed two statutes which remain in force, subject to several major amendments, today: The Canadian and British Insurance Companies Act, 1932 (S.C. 1932, c.46) (hereinafter the "C & B Act") and The Foreign Insurance Companies Act, 1932 (S.C. 1932, c.47) (hereinafter the "Foreign Act").

3.2 Both Acts opened with recitals which were intended to underpin the competence of Parliament to legislate, and both Acts closed with a declaration that if any provision were held to be beyond the legislative competence of Parliament, it was to be treated as severable.

3.3 Generally, the C & B Act applied to companies incorporated by special Act of Parliament after May 4, 1910; to companies incorporated before that date but not licensed before that date; and, to companies incorporated under the laws of the Dominion of Canada or the Province of Canada to carry on the business of insurance, which was defined as "...the making of any contract of insurance, and includes any act or acts of inducement to enter into such a contract, and any act or acts relating to the performance thereof, or the rendering of any service in connection therewith....(subsection 2(d)). This definition has not been amended since 1932.

The C & B Act also governed every British company transacting business in Canada. "British company" was defined as "...any corporation incorporated under the laws of the United Kingdom of Great Britain and Northern Ireland or any British Dominion or possession other than Canada or a province of Canada for the purpose of carrying on the business of insurance and includes 'association' as defined by this Act..." (subsection 2(c)). It should be noted that "association" was defined to include Lloyds (subsection 2(b)). In addition, a provincial company could register under the C & B Act and thereby certain sections of the C & B Act would apply to it (sections 149 and 154). A "provincial company" was defined as "...a company incorporated under the laws of the province of Canada or of any former province of British North

America now forming part of Canada other than the late Province of Canada for the purpose of carrying on the business of insurance...." (subsection 2(n)).

The Foreign Act applied to each company "....incorporated under the laws of any foreign country for the purpose of carrying on the business of insurance, and includes 'association', 'exchange' and 'fraternal benefit society' as respectively defined by this Act...." (2(g)).

Minor amendments have been made to these provisions but, on the whole, the scope of these Acts have remained unchanged to the present.

3.4 Both acts were amended during the 1930s, '40s and '50s; many amendments were made, in particular to the investment provisions.

3.5 In 1956, the minimum amount of statutory deposits was increased under both Acts (C & B Act: S.C. 1956, c.28, and Foreign Act: S.C. 1956, c. 30).

3.6 In 1957, significant amendments were made to the C & B Act. The requirement that a majority of directors be "ordinarily resident in Canada" was introduced (S.C. 1957-58, c.11, section 2). The directors of life insurance companies were given discretion to refuse to register transfers of stock to non-residents (broadly defined) unless the stock was already held by a non-resident (section 3). Finally, life insurance companies with capital stocks were authorized, with the permission of the Minister, to convert to mutual companies and detailed provisions for such conversions were enacted (section 4).

3.7 In 1965, the non-resident ownership provisions pertaining to life insurance companies were tightened considerably. Directors were required to refuse transfers of stock to non-residents which would result in more than 25 per cent of the total issued and outstanding stock being owned by non-residents, or more than 10 per cent of such stock being owned by a single non-resident. A new life company, however, could be owned by non-residents so long as the shares were issued before the day on which the first general meeting of shareholders was held. (These provisions have never been extended to companies carrying on business other than life insurance.

3.8 A requirement that each company subject to the C & B Act appoint an auditor for the purpose of completing an annual report to directors and the Superintendent was added in 1970 (S.C. 1969-70, c.14, section 24). In addition, the Superintendent and the Minister were given certain powers to intervene where the assets, in the case of a life company, could not be accounted for satisfactorily (subsection 28(1)) or where, in the case of a general company, the assets fell below the statutory standard of solvency (section 34).

Minimum unimpaired capital stock and surplus requirements for registration purposes were introduced (subsection 16(2)) as follows:

life company:	paid-up capital stock - at least \$1,000,000
	surplus - at least \$ 500,000
	total - at least \$2,000,000
general company:	paid-up capital stock - at least \$ 750,000
	surplus - at least \$ 250,000
	total - at least \$1,500,000

3.9 In 1977, companies under the C & B Act were given additional powers to carry on other business (S.C. 1976-77, c.39, section 2):

4.6(1) A company may, with the consent of the Minister, carry on any business that is reasonably ancillary to the business of insurance transacted by the company.

Also, new solvency tests for minimum assets to be maintained by general companies were put in place (subsection 17(1)).

4.0 ELEMENTS OF CONTROL: INSURANCE ACT (ONTARIO) AND CANADIAN AND BRITISH INSURANCE COMPANIES ACT* (CANADA)

4.1 Incorporation

4.1.1 Ontario

Joint stock insurance companies, mutual insurance corporations, cash-mutual insurance companies, fraternal societies and mutual benefit societies may be incorporated under the provisions of the Corporations Act, R.S.O. 1980, c.95, Part V (Insurance Corporations). It should be noted that the definitions included in section 1 of the Insurance Act also apply to Part V of the Corporations Act. Insurance means (subsection 1.3.0.) "...the undertaking by one person to indemnify another person against loss or liability for loss in respect of a certain risk or peril to which the object of the insurance may be exposed, or to pay a sum of money or other thing of value upon the happening of a certain event and includes life insurance." Thus the objects of an insurance company will be limited to insurance (although it will have the incidental powers set out in section 23 of the Corporations Act).

The Lieutenant Governor may, in his discretion, by letters patent issue a charter to the prescribed number of qualified persons (subsection 4(1)). The Act does not contain any standards of integrity, experience or fitness for the incorporators.

The Corporations Act also governs certain features of corporate structure and governance. For instance, directors must hold qualifying shares in a joint stock insurance company (section 209). The shareholders are required to appoint auditors (sections 94 and 95).

4.1.2 Federal

Although, in the early years, federal companies were incorporated by special act, they are now incorporated by letters patent issued by the Minister of Consumer and Corporate Affairs with the concurrence of the Minister of Finance (subsection 4.1(1)). Provincially-incorporated companies also may apply for letters patent through a trans-jurisdictional incorporation procedure (section 4.5). The

* Canadian companies only.

effect of the letters patent is to create a corporate body "...for the purpose of carrying on the business of insurance..." (which is defined above in section 3.3). A federal company since 1977 has had additional powers as follows (emphasis added):

4.6 (1) A company may, with the consent of the Minister, carry on any business that is reasonably ancillary to the business of insurance transacted by the company.

(2) A company may provide administrative, advisory and management services to any corporation where the company holds shares of that corporation acquired under section 64 or 65.

A federal insurance company therefore is limited in its objects. The C & B Act does not delineate incidental powers, although it does provide as follows:

4.1 (2) A company incorporated by letters patent pursuant to subsection (1) is invested with all the powers, privileges and immunities conferred by this Act, and applicable thereto, and is subject to all the limitations, liabilities and requirements set forth in this Act, and applicable thereto, and has the like capacity of a company incorporated in the manner described in section 4 [by special act].

The C & B Act governs certain features of corporate structure and governance. Directors must hold qualifying shares in a joint stock company (subsection 6(3)). Agents cannot be appointed directors, and the number of paid officers who can sit on the board is limited to two in addition to the President and Secretary (subsection 6(10)). Shareholders are required to appoint auditors (section 78.1 and section 3.8 above). As above, the Act does not contain any standard of integrity, experience or fitness for the incorporators.

4.2 Licensing

4.2.1 Ontario

The following entities are required to be licensed in Ontario:

*an insurer undertaking a contract of insurance deemed to be made in Ontario (subsection 20(2))

*an insurer carrying on business in Ontario (subsection 20(3))

*underwriters agencies (section 91)

*reciprocal or inter-insurance exchanges, which, however, are distinct from insurers (sections 332 and 335)

It is clear that a licensed insurer may enter into a contract with an unlicensed reinsurer so long as the reinsurer can be said to be "...transacting business out of Ontario..." (section 22). The result is that a reinsurer need not be licensed in Ontario merely as a result of contracting with an Ontario-licensed company. The key question is the situs of the contract.

Although section 9 provides that it is within the discretion of the Superintendent to decide whether a licence should be granted, subsection 23(1) states that the Minister issues the licence. Subsection 23(2) establishes the scope of the licence as follows:

23. (2) A licence issued under this Act authorizes the insurer named therein to exercise in Ontario all rights and powers reasonably incidental to the carrying on of the business of insurance named therein that are not inconsistent with this Act or with its Act or instrument of incorporation or organization.

Most types of insurers applying for a licence must make a deposit of approved securities with the Minister, although the amount of such deposit is in no case greater than \$50,000.00 (subsection 46(1)). In addition, those licensed after January 1, 1971 must meet minimum capital or surplus requirements (section 28) which may be set at the levels determined appropriate by the Minister. Bill 108 (An Act to amend the Insurance Act) was introduced on February 12, 1986. It contains amendments to section 28 which will increase the minimum aggregate amount for a non-life insurance company to \$3,000,000 with a transitional phase to continue until 1991 to allow all companies to move from the current minimum of \$1,000,000. There is provision for the Lieutenant Governor in Council to exempt an insurer from these requirements "...if the insurer is offering its services only within Ontario or if the insurer is offering a specialized or limited service that in the opinion of the Lieutenant Governor in Council does not require the support of higher capital requirements...".

An insurer which has complied with the Act and the Corporations Act is entitled to a licence, although the licence may be subject to limitations and conditions (subsection 24(4) and subsection 25(4)). If a licence is varied at any time other than upon issuance or renewal, the Minister must give to the insurer notice of such change and a reasonable opportunity to respond.

4.2.2 Federal

If a company does not hold a certificate of registry from the Minister, it is prohibited from transacting the "business of insurance" except as may be required for the protection of the company's policyholders (subsection 52(1)). Marine insurers are exempted from the registration requirement (subsection 101(2)). A certificate of registry may contain limitations or conditions (subsection 55(4)) and it may be varied during its term if certain procedural safeguards are met (subsection 55(5)). The Superintendent is under a statutory duty to make a report to the Minister, with respect to an insurer's compliance with the Act and its financial condition before the granting or renewal of any certificate of registry.

4.3 Share Ownership - Upstream

4.3.1 Ontario

Neither the Insurance Act nor the Corporations Act limits who may be a shareholder. The Superintendent must be given thirty days' notice of any transfer of shares equal to ten per cent or more of an insurers' issued and outstanding shares and of any transfer which would result in one person owning, directly or indirectly, a majority of the shares of the insurer (section 79). No statutory authority is given to intervene in such transfers.

4.3.2 Federal

Notice of any transfer of ten per cent or more of the total outstanding shares of a company, or of ten per cent or less if the transfer would result in one person owning, directly or indirectly, a majority of the shares, must be given to the Superintendent thirty days before the transfer (section 10.1). The Superintendent does not have any statutory power to intervene in the transfer.

The C & B Act limits non-resident ownership of life insurance companies (see: section 3.7 above) but it does not contain similar provisions with respect to companies transacting other than life insurance business.

4.4 Investments Generally

4.4.1 Ontario

The types of investments which are permissible for insurers incorporated or organized under the laws of Ontario are governed by Part XVII of the Act. The

Superintendent may order appraisals of assets held by an insurer if the Superintendent has reason to believe that the values shown in the annual statement are inflated and the Superintendent may change such values and report such changes in his annual report (subsections 17(4) to (6)).

4.4.2. Federal

A company subject to the C & B Act may invest only in such securities as are prescribed by the Act (section 63). The Superintendent has similar powers with respect to appraisals of real estate (section 75) as under the Ontario Act. The federal Department has proposed to amend section 75 to give the Superintendent greater remedial powers. Instead of being limited to stating the changed value in his annual report, he will be given authority to use the changed value for purposes of the solvency test and all other provisions of the legislation. Such powers will extend to the real estate holdings of subsidiaries.

4.5 Investments - Downstream Subsidiaries

4.5.1 Ontario

Generally, an insurer may invest in common shares of a corporation only if those shares meet one of the earnings tests specified (paragraph 388(1)). A life insurance company, however, has an expanded authority to invest in the fully paid shares of certain other corporations (subsection 388(8)). Insurers licenced to transact business other than life insurance do not have such expanded powers.

4.5.2 Federal

Generally, an insurer may invest only in common shares which meet specified earnings tests (paragraph 63(1)(m)) subject to a maximum limit of thirty per cent of the common shares of any corporation. These limits may be exceeded however, by a non-life insurance company as follows:

64. Notwithstanding anything in subsection 63(1), a company, other than a company registered to transact the business of life insurance, may invest its funds in the fully paid shares of

- (a) any other corporation transacting the business of insurance, and
- (b) with the prior approval of the Minister, any corporation incorporated to carry on any other

business that is reasonably ancillary to the business of insurance transacted by the company,

subject to such terms and conditions as may be prescribed by the regulations.

Life insurance companies are also given expanded investment powers in subsidiaries in section 65.

4.6 Minimum Financial Requirements

4.6.1 Ontario

All insurers must have under their control assets in Canada at least equal to their total liabilities to policyholders in Canada (subsection 392(2)). Although the Act provides for the calculations of life insurance reserves, it is otherwise silent on how liabilities and assets are to be calculated. Woods, Gordon & Co. prepared a report for the Select Committee on Company Law in January 1978 (Report XI: Solvency and Liquidity Rules). It detailed the Department's in-house rules. Notwithstanding the recommendation of the Committee as noted in that Report, rules for this purpose have not been statutorily enacted.

4.6.2 Federal

The C & B Act provides, in subsection 103(1), detailed rules for determining the minimum amount of permissible assets required to be maintained by a company, which must be maintained in Canada. These assets may be reduced where a liability has been reinsured with a licensed reinsurer (subsections 103(1.15) to (1.19)). Amendments have been proposed to this section. In addition, it is anticipated that new reserves will be required (under subsection 71(4)) for amounts due from agents and affiliated companies.

The payment of dividends is prohibited where a company's capital is impaired, the assets are less than minimum or the payment of the dividend would reduce the assets below the minimum amount (subsection 103(3). Further, if dividend payments can be made, the amount is limited as provided in section 105. The Department has proposed an amendment to section 105 which would lower the ceiling on allowable dividends if the statutory capital and surplus of a company is less than \$5,000,000. The intended result is that more profit will be retained in smaller companies and surplus will grow.

4.7 Accountability Mechanisms

4.7.1 Ontario

Historically, the major mechanisms on which the Superintendent has relied have been: 1) the requirement for an insurer to file an annual statement in the form prescribed by the Superintendent not later than the last day of February (subsection 8(1)), which statement must also be verified in the manner prescribed and 2) the requirement that the Superintendent attend upon each insurer annually to conduct an examination (section 15).

Generally, the Superintendent and the Minister have been given remedial powers which can be invoked in certain circumstances. The Minister may suspend or revoke a licence where:

- *an insurer has failed to pay an undisputed claim (section 36)

- *an insurer has failed to keep its deposit unimpaired (section 37)

- *upon completing certain procedural requirements (including giving the insurer a reasonable time to be heard), the assets of an insurer are insufficient or it has failed to comply with the Act or its constating documents (section 30)

Further, where an insurer cannot satisfactorily account for its assets, the Superintendent may take control of the assets of an insurer (section 39). The Superintendent must report to the Minister (whether or not he has taken control of the assets of an insurer) when the former is "of the opinion that the assets...are not sufficient to justify its continuance in business or to provide for its obligations under its policies" and thereafter procedures are prescribed for requiring certain remedial measures to be taken by the insurer, taking control of the assets of the insurer if the remedial measures are not satisfactory, rehabilitation of the insurer or winding-up of the insurer (sections 40-41).

The Superintendent has access to the books of an insurer (section 13) and an insurer must respond to inquiries (section 14). The Superintendent may require the filing of certain statistical returns on experience in general lines (section 80). The Superintendent may also require the filing of insurance policies from time to time (section 94).

The Act contains certain general controls on the contracts of an insurer, the most important being:

103. (1) No insurer shall make a contract of insurance inconsistent with this Act...

94. (2) The Superintendent shall report to the Minister any case where an insurer issues a policy or uses an application that, in the opinion of the Superintendent, is unfair, fraudulent or not in the public interest, and after hearing the insurer the Minister may, if he concurs in the report, order the Superintendent to prohibit the insurer from issuing or using such forms of policy or application.

Further, Part XVIII of the Act prohibits certain unfair and deceptive practices (section 394) and gives the Superintendent the power to issue a cease and desist order (section 395).

4.7.2 Federal

The C & B Act requires that an annual statement be filed in provisions similar to those of the Ontario Act (section 70(1)). While a life insurance company must report changes in investments and loans on a half-yearly basis, a non-life insurance company is not subject to the same requirement. It is proposed, however, to amend the C & B Act to require any company to file interim financial statements in such detail and with such frequency as required by the Superintendent.

Currently, the C & B Act provides that the annual statement must include a report by a valuation actuary with respect to any reserve shown for non-cancellable accident and sickness policies and for claims under accident and sickness policies payable in instalments (subsection 102(4)). It is proposed to amend this provision to require that each company submit a special report signed by an actuary, stating that in the actuary's opinion, the provision for outstanding claims represents a fair and reasonable estimate of the amounts that will be required, together with the amounts receivable from reinsurers, to settle the claims in full. The proposed amendment therefore is a significant change and it is anticipated that transitional provisions will be put in place.

The Superintendent is required to conduct an examination of each insurer annually (subsection 72(d)).

The Superintendent is required to report to the Minister in certain situations which signal that an insurer may be in difficulty (subsection 103.2(1)). The Minister is authorized to take certain action after giving the insurer a reasonable time to be heard. These actions are:

103.2(2)...

- (a) he may make the company's certificate of registry subject to such limitations or conditions as he considers appropriate;
- (b) he may prescribe a time within which the company shall make good any deficiency or inadequacy of assets...; and
- (c) he may direct the Superintendent to take control of the company's assets.

The C & B Act prescribes the procedures to be followed when control of a company's assets is taken and the result may be either rehabilitation or winding-up of the insurer (section 103.3).

The Superintendent has access to the books of an insurer during an inspection (subsection 73(1)). Insurers are under a statutory duty to respond promptly to inquiries from the Superintendent (section 76).

**5.0 ELEMENTS OF CONTROL: CANADIAN AND BRITISH
INSURANCE COMPANIES ACT* AND FOREIGN INSURANCE
COMPANIES ACT (CANADA)**

5.1 Licensing

Both British and foreign companies are prohibited from transacting the "business of insurance" in Canada unless they hold a certificate of registry (section 122 and section 4). Conditions or limitations may be added to a certificate by the Minister on renewal; a change may be made at any other time subject to the obligation of the Minister to give the insurer an opportunity to be heard (subsection 126(4) and subsection 19(4)).

5.2 Minimum Financial Requirements

Canadian branches are required to maintain minimum assets in Canada calculated on the same basis as Canadian-incorporated companies (section 128 and section 14). It is proposed to increase these requirements as for Canadian companies. These assets may be vested with a trust company (section 129 and section 20) or they may be placed on deposit with the Receiver General. Permissible securities are prescribed for both categories of assets. (It should be noted, however, that British and foreign companies may make investments in Canada other than those minimum assets required and such investments are essentially unregulated.)

5.3 Accountability Mechanisms

In addition to the requirement to file annual statements with respect to its Canadian branch (section 130 and section 21), each registered company is also required to file its general business statements (that is, the statement reporting its worldwide business which is required by its jurisdiction of incorporation (section 131 and section 22)). It is proposed that both British and foreign branches be required to file interim financial statements when requested by the Superintendent, and to add certification by a valuation actuary.

The Chief Agent for Canada of British and foreign branches is under a statutory obligation to keep certain records which are available to the

* British companies only.

Superintendent (sections 132 and 24). The Superintendent is required to conduct an annual examination of the branch, and the Minister may also order a head office examination (section 136 and section 31).

The Minister may withdraw the certificate of a British company and, if it is not renewed within 30 days, the branch is deemed to be insolvent and subject to be wound up (section 145). This summary procedure is not available in the case of foreign branches.

Where the assets of a branch are insufficient for the protection of policyholders in Canada, the Superintendent must so report to the Minister who has several remedial powers which can be used on notice to the branch, including taking control of the assets of the branch (section 146 and section 51).

6.0 RECENT STUDIES ON THE REGULATION OF CANADIAN FINANCIAL INSTITUTIONS

6.1 A series of reports published in the last year have made a variety of recommendations with respect to the regulation of financial institutions. The three to be discussed herein are:

Department of Finance - Canada: The Regulation of Canadian Financial Institutions: Proposals for Discussion (April, 1985) (hereinafter the "Green Paper")

Report of the Standing Committee on Finance, Trade and Economic Affairs: Canadian Financial Institutions (November, 1985) (hereinafter the "Blenkarn Report")

Ontario Task Force on Financial Institutions (December, 1985) (hereinafter the "Dupre Report")

6.2 The impetus for these studies arose from two sources. On the one hand, the types of financial intermediaries often referred to as the "four pillars" of our financial markets (banks, trust and loan companies, insurance companies and securities dealers) were urging that the traditional approach of separation of powers of financial intermediaries be altered to allow such intermediaries to compete directly, thereby fueling growth. On the other hand, intermediaries were failing at a startling rate, with the result that public decision-makers were pressed to increase the level of control by designing and implementing mechanisms to protect consumers and ensure market stability.

6.3 It should be noted that life insurers are considered to constitute the insurance "pillar", not property casualty insurers. Life insurers play a much greater intermediation function than do property casualty insurers. Although for policy analysis purposes the two types of insurers were treated as being similar, the validity of that premise is questionable.

6.4 None of the reports recommend that the separation of powers model be changed. Their principal focus was on how the separate entities could be arranged so as to accommodate the aims of both the regulated and regulators. The Green

Paper and the Dupre Report opted for the consolidation of ownership interests in separate entities in an upstream holding company and approved of the concept of an additional type of bank which could be closely held:

A federally-incorporated financial holding company would be required if a federally-regulated financial institution were among a group of two or more financial institutions operating under different legislation that shared a common 'substantial shareholder'; that is, an investor or group of associated investors that held more than 10 per cent of the voting shares of each of the companies involved. (Green Paper, at pp. 31-32)

It should be a principle of public policy that ownership links between financial institutions operating under different legislation should be permitted only through a financial holding company... (Dupre Report, at p.12)

The Blenkarn Report rejected the structural rigidity of this approach and recommended that:

...non-bank financial institutions be allowed to diversify flexibly through upstream holding companies and affiliated institutions, downstream holding companies and subsidiaries, together with some limited expansion of in-house rules [particularly with respect to commercial lending] and networking arrangements (Blenkarn Report, at p.15).

6.5 It follows from the choice to maintain separate corporate identities by function that some form of linkage between the entities must be sanctioned. All these reports supported networking (excluding tied selling) amongst entities (whether affiliated or not).

In the view of the Dupre report, however, networking arrangements should be regulated through disclosure requirements:

When two or more financial institutions propose to enter into a contractual arrangement in regard to the sale of financial products or services, such an arrangement should require the approval of whichever regulators may be responsible for the supervision of the respective contracting parties. Before approving any arrangement, the regulators should be satisfied that the proposed arrangement will not result in practices that are directly or indirectly akin to tied selling, that the contracting parties possess the necessary expertise to offer the services that are the subject of the arrangement, and that they have procedures in place to guard their customers against any adverse consequences as a result of any conflicts

of interest arising from the arrangement. In assessing the desirability of particular networking arrangements, the regulators should take favourable note of arrangements designed to enhance consumer services in small communities. (at p.15)

The Dupre Report noted that 84 per cent of insurance in Ontario is routed through brokers (at p. 73) and recommended that the role of independent agents and brokers be supported:

In particular, the Government of Ontario should take special care that its own regulatory and policy initiatives taken with regard to financial institutions will preserve a climate that is favourable to the role played by independent agents and brokers in enhancing competition and quality of service... (at p.74)

6.6 The reports did not include any projections of the effects which such structural changes are likely to have on the way the insurance industry does its business and on its profitability.

6.7 All three reports stated that the primary concern of both public decision-makers and consumers with respect to financial intermediaries was solvency. The Green Paper concluded:

One of the questions raised by recent developments in Canada's financial system is the following: has the development of links among different types of institutions had a bearing on the risk of insolvency... given the diversity of financial system structures currently in place around the world, there does not appear to be any clear connection between the stability of a financial system and any particular structure. (at p.15)

6.8 Although the reports contain some commentary on the reasons for the failures of various financial institutions, the analysis is not general and most of the examples are drawn from banking and trust company sectors. A comment on the circumstances of failed property casualty insurers was included in the Blenkarn Report:

A few factors have played a major contribution in the insolvencies that have occurred: inadequate capitalization, failure to maintain sufficient premiums, understatement of liabilities and inadequate reinsurance protection. (at p.102)

It should be noted that these reasons differ significantly from the circumstances of failed trust companies and banks.

6.9 Both the Blenkarn Report and the Dupre Report make recommendations in response to current inadequacies in both regulatory powers and statutory approaches to corporate government. A number of these recommendations have been included in the proposed federal amendments and Bill 108 (Ontario), in particular:

FEDERAL-BLENKARN REPORT

- proposed amendment to subsection 103(1) with respect to minimum continuing capital and surplus requirements

(NOTE: "On an overall basis, the inclusion of this test would not have a major impact on the current solvency margin of the property and casualty industry. It would help to correct certain technical flaws... and would affect a few companies which today are able to operate with a very small capital base in relation to their operations and still pass the present tests." (at p.102)

- proposed reinsurance regulations (although the Superintendent's proposals go well beyond the single recommendation in the Blenkarn Report that premiums ceded to a non-registered insurer cannot exceed those ceded to a registered insurer, at p.105)
- actuarial reports in respect of claims and unearned premium reserves
- cease and desist orders

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- compensation associations (property-casualty only) (at. p.10)
- higher initial capitalization (at p.23)

In fact, however, the majority of the recommendations in both reports have not been included in the proposed legislation. Some of the recommendations hinge upon decisions about the purposes and design of the regulatory structures, while others require a major overhaul of corporate governance.

7.0 AGENTS AND BROKERS

7.1 Agents

It will be recalled that insurance agents in Ontario have been subject to a statutory requirement to be licensed since 1914. "Agent" is defined in the Insurance Act (subsection 1.15) and does not include (inter alia) a member of Registered Insurance Brokers of Ontario. Individuals, partnerships or corporations may be licenced in three categories: life insurance (which can be combined with accident, or accident and sickness insurance), accident and sickness insurance, and all other classes of insurance. A person may hold two licences in respect of life insurance and all other classes of insurance. Agents who are employees of insurers have not, to date, been required to hold a license.

A person is not entitled to a license as a matter of right but must be: 1) appointed by an insurer; and 2) a suitable person who intends to hold himself out publicly as an agent and carry on business in good faith. An agent can be appointed by only one company (except in the case of an agent licenced for life and accident insurance, or life and accident and sickness insurance. (A life insurance may, with the written consent of the appointing company, procure insurance from another insurer which the agent has not be able to negotiate with the appointing company.)

The majority of the issued and outstanding shares of corporations carrying on business as agents must be owned by residents of Canada unless the agent was licenced on or before April 27, 1972. A corporation which has been so "grandfathered" is not entitled to continue to hold its licence if it combines its business with that of another licenced agent.

A licence may be revoked by the Superintendent only for certain stated reasons (including incompetency or trust worthiness) after granting a hearing to the agent.

7.2 Brokers

Since 1980, brokers have been regulated pursuant to the Registered Insurance Brokers Act (R.S.O. 1970, c.444). The statutory definition of "broker" is broader than the common law definition and includes (subject to certain specific exemptions, eg. an employee of an insurer) any person who provides any service directly to the public with respect to contracts of insurance other than life

insurance. Brokers are not required to be licensed by the Superintendent; instead, they must be registered by the Registered Insurance Brokers of Ontario, a Corporation continued under and governed by the Act. The principal provisions governing qualification are contained in regulations made by the Lieutenant Governor in Council under the Act.

APPENDIX 1C

PROFESSIONAL LIABILITY INSURANCE

A paper delivered April 22, 1986 to the Slater Task Force on Liability Insurance by W. Donald Lilly, Q.C., a member of the Insurance Advisory Committee.

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INTRODUCTION

The Task Force is to cover cost and capacity problems, possible approaches to resolving problems and proposals to create on a long-term basis increased market stability, policyholder protection and a climate of economic opportunity for insurance companies in Ontario.

When completed, the Task Force Report will be given wide circulation and there will be full opportunity for public response.

This paper is to deal specifically with professional liability insurance. Since the Task Force is dealing with the larger questions on a broad basis this paper is limited as follows:

- (a) It is based on interviews, submissions, discussions with members of the Task Force and Advisory Committee, specific information from statistical data where available and general research, but in the limited time and with the limited financial information available, it can be no more than general impressions. Public response to the paper will no doubt refine the information.
- (b) While it appears that premiums have risen dramatically and limits have contracted, we make no attempt to explain why, nor do we intend to convey any criticism or approval. The workings of the insurance industry are covered by Dr. Slater's report which provides recommendations to strengthen and enlarge the insurance industry role in the protection of professionals.
- (c) The benefits or problems associated with self insurance are covered by Dr. Slater's report. We refer to self insurance here because it has become one of the initiatives taken by some associations.
- (d) Details of recommendations are left to be worked out in the future. They are conceptual only. We hope they provide the way to some solutions.

PART I: OVERVIEW

A. THE TRADITIONAL INSURANCE MARKET

1. Errors and omissions insurance at present premium levels for all professionals across Canada would require premium capacity in excess of \$100,000,000.
2. Few of the major insurers write this kind of business. Many of the specialty insurers have ceased doing so. Only the Simcoe & Erie pool remains as a substantial insurer in this class. The other remaining insurance facilities have little impact on capacity. This is not likely to change for several years because reinsurance is almost unattainable.
3. Most of the reinsurance comes from Lloyds. It regards Ontario in the same light as it does the United States, where in professional liability it has had disastrous results. Lloyds are not likely to reenter the professional liability reinsurance field in North America for a very long time. The American reinsurers will likely serve the enormous needs of the American market in preference to the Canadian market.
4. Professionals are faced, therefore, with long-term restricted availability, and the present insurers, including the Simcoe & Erie pool, cannot be expected to provide coverage to all professionals across Canada at current limits and deductible levels. Professionals relying on the traditional insurance market must get used to lower limits, higher deductibles and, for a certain percentage of the professions, no insurance at all.

B. SELF INSURANCE

5. Some professionals are responding by setting up self insurance facilities. Since this will provide extra capacity, they should be encouraged. Any legislation necessary to prevent contravention of the Insurance Act should be passed and implemented on an urgent basis.
6. This can be done if the government sponsors excess and reinsurance facilities which otherwise will be unavailable to them. The government should be prepared to do so if it insists (as in the case of architects and engineers) on insurance as a mandatory or compulsory pre-condition to a licence to practice. The reinsurance facility on a commercial basis could be on the

condition that losses would be paid back by the professionals over a specified time, say a 10 year period.

7. The very large engineering and accounting firms are involved in a variety of activities worldwide, including activities in the United States. This has resulted in severe reinsurance problems. Because their potential exposure is enormous, they require at least \$100,000,000 limits. The reinsurance market is not able to provide limits of more than about \$25,000,000.

They are interested in setting up their own self insurance facility and can back it with their own assets to a very high primary layer. But they need catastrophic loss protection to protect them from liability disaster. If we believe in an international presence, the government should sponsor a reinsurance pool at the upper limits and provide tax benefits to allow a quick reserve build up to meet any catastrophic loss that might occur.

8. While the judicial system is not at the root of the insurance crisis, there are a number of specific legal problems which, if solved, may help to control unfair risk exposure. They include prejudgment interest, collateral benefits, limitation periods, Family Law Reform Act awards, joint and concurrent liability, OHIP subrogation and other like matters. They are discussed separately under Part III.

PART II: THE CURRENT INSURANCE SITUATION

A. ARCHITECTS & ENGINEERS

The Architects and Engineers are represented by the Ontario Association of Architects, the Consulting Engineers of Ontario and the Association of Professional Engineers of Ontario.

Each of these associations has association sponsored errors and omissions policies underwritten by the Simcoe & Erie pool and managed by National Insurance Managers, Inc. (NIM, formerly National Program Administrator).

Simcoe & Erie is an Ontario licenced insurer with considerable experience in the professional liability field. Its capital base has recently been augmented by outside investors. As well, it manages a pool of money from a number of other insurers interested in insuring professionals. Its combined capital base, experience and interest in the professional liability field will provide a very significant source of errors and omissions insurance for professionals across Canada for the future.

NIM is a management service not normally found in an insurance program. It is owned jointly by Simcoe and Erie Investors Limited, Simcoe & Erie General Insurance Company and ENCON Insurance Managers Inc. It performs some of the underwriting functions of Simcoe & Erie and provides risk management seminars to the professions.

Other insurers have provided competing insurance policies until recently. While none of them were endorsed by the associations, they provided important capacity and premium competition. Of particular note were L. W. Biegler and Coronation, which provided about 20% of the capacity. Both of these companies no longer provide this insurance.

Others such as Markel and INAPRO withdrew over the last two years. Kansa continues to write a small volume of selected risks as does American Home, but there is only one remaining underwriter which can significantly serve the needs of architects and engineers across Canada and that is Simcoe & Erie.

While several reasons are given for the withdrawal of the other insurers, it always relates back to the one recurring problem—an inability to put together a reinsurance program.

1. Availability and Premiums

There are no accurate statistics as yet available. But reasonably accurate conclusions can be made from the information available.

At current premium levels, over \$100,000,000 of premium is required to cover all professionals insured by the traditional market (i.e. architects, engineers, accountants, brokers, surveyors, nurses, etc.) across Canada. It is highly unlikely that the Simcoe & Erie program would dedicate that much investment to professional liability insurance.

Clearly, other facilities must be established. Indeed, there is presently a great deal of activity by the large brokerage houses to put together new facilities, but they are all met by the same problem. There is no suitable reinsurance available to them.

This problem is not a temporary cycle. Lloyds has historically provided most of the reinsurance in this field. It looks on Canada (and Ontario in particular) as merely an extension of the United States, and there, the professional liability insurers have experienced disastrous results. Last year, 33% of architects and engineers in California were left to practice without insurance and this year Lloyds has simply withdrawn from North America. The underwriters we talk to at Lloyds say they have no plans to return in the foreseeable future. They have lots of capital but they can put it to much better use elsewhere.

The American reinsurers likewise regard Ontario as the "California of the North". While American Reinsurance is involved on the Simcoe & Erie program, it is unlikely that other American reinsurers can be persuaded to invest in new professional liability facilities.

Canadian Reinsurance, a subsidiary of Swiss Reinsurance, was for years the major reinsurer on the Simcoe & Erie program. It withdrew from that facility over a year ago and is not likely to reenter the market for a new facility.

There is also the concern about premiums. It is the Associations' overall impression that for those insured in the Simcoe & Erie program, premiums increased this year on average about 60%. For those moving from the other facilities, the premium increases were between 200% and 300% with some quote increases as high as 1000%.

The most accurate statistical data comes from a recent RIMS survey for the United States and Canada which indicates the following:

RIMS SURVEY

USA & CANADA

Availability:

Easy to Purchase	15%
Somewhat Difficult	21%
Much Difficulty	26%
Unavailable	11%
Not Renewed	9%
Cancelled	4%
Not Purchased	31%

Change in Premiums:

Decrease	4%
No Change	10%
Increase 1-10%	8%
Increase 11-50%	19%
Increase 51-100%	18%
Increase 101-200%	12%
Increase 201-500%	18%
Increase over 500%	11%

Additional information has been provided by association surveys as follows:

- (i) An OAA 3-year survey indicates total gross fees of all practicing architectural firms is \$275,000,000. Premium rates in 1984, depending on the size and type of firm and coverage provided, varied from \$1.70 to \$2.90 per \$100 of gross fee income.

In 1985/86 rates on average appeared to be in the \$4.75 to \$8.25 range, with the lower end providing only minimal coverage with a much larger (\$50,000) deductible.

Because of their inability to pay the high premium cost, 40% of those firms having a total staff of three or less (these represent 46% of all practicing firms) are currently uninsured.

In total, 35% of all practicing architects are uninsured.

- (ii) An APEO July 1985 survey indicates that 16% of its 45,000 member association cannot buy errors and

omissions insurance at any price. An additional 15% (1,500 engineers) have not purchased it because the cost is so high that the firms simply cannot afford it and remain financially viable.

It is virtually impossible to purchase limits of over \$1,000,000. Specific insurance policies for specified projects in excess of a \$1,000,000 limit is available but at exorbitant cost. Recently, one firm required \$5,000,000 limits for a relatively simple project. The cost of this insurance was \$8,000, while the related engineering fee was \$50,000.

Premium increases ranging from 60% to 500% and more were reported. Premiums are now running generally from 1 1/2% to over 6% of gross billings with coverage shrinking and deductibles increasing. A few years ago by comparison, premiums ranged from 1/2% to 1 1/2%.

The very large engineering firms which historically required \$25,000,000 limits and considerably higher for some projects now find that \$10,000,000 is the maximum available with only \$5,000,000 limits for projects in the United States. One engineering firm did get \$20,000,000 for a project but this does not seem to be representative.

For their reduced limits these firms are paying overall premium increases of 70% and more with premiums exceeding \$1,000,000.

They also have severe comprehensive general liability coverage problems for their products sold in the United States. One such firm had \$100,000,000 limits for a subsidiary selling products in the United States. This was reduced to \$1,000,000 limits costing more in premium than it paid for the higher limit.

Clearly, long-term solutions must be found.

Capacity must be increased and reinsurance at affordable premium levels must be available.

Some professional associations are responding by trying to set up self insurance facilities. They believe that they are in an ideal position to self insure. They are disciplined and organized and they are capable of sophisticated educational and risk management programs to control losses. Their self insurance retention would demonstrate to reinsurers a meaningful and direct interest in their

well-being. They could keep the kind of statistics which reinsurers want at renewal.

We understand that some layers of reinsurers are reasonably receptive to self insured programs provided that the associations come with rational risk analysis and rate studies. But some layers may be unavailable or available only at unacceptably high premium levels.

The Ontario government can solve that problem by providing to the self insured professionals reinsurance on a commercial basis. In the event of loss, the profession should reimburse the government over some time at an agreed interest rate. Such participation is justified on the following grounds:

- (a) At present, architects and engineers will be required on a mandatory or compulsory basis to obtain insurance as a precondition to a licence to practice. If the government insists on this precondition, it has the duty to ensure that the insurance is available at acceptable premium levels;
- (b) Coverage provided protects the public at large in the event that some members of the community incur damage;
- (c) The government sustains no financial loss if the profession reimburses it over time for losses paid out plus interest;
- (d) The international insurance crisis is too large for the professionals to solve by traditional methods. The situation justifies government intervention.

2. Compulsory/Mandatory Insurance

In the late 1970's and early 1980's, the Province of Ontario undertook a detailed review of legislation governing engineers, architects, lawyers and accountants. A major thrust of this review was protection of the public. After study, negotiation and compromise, Bill 123 was introduced to require insurance on a compulsory basis. It has not as yet been implemented, largely because of the difficulty in obtaining insurance.

The engineers in particular strongly urge that the notion of compulsory insurance be abandoned. They argue that:

- (a) In the case of the Association of Professional Engineers of Ontario (APEO) about three-quarters of the member

engineers are working as employees for government or manufacturers who have existing insurance protection. Therefore only about 10,000 members are truly consulting engineers who do not have this already existing protection.

- (b) These remaining 10,000 member consulting engineers do not work directly for the public. They are engaged by business clients who themselves have insurance and assets to respond to claims from the public.
- (c) The consulting engineers perform a wide variety of comparatively unrelated functions (i.e. design and supervision of construction, manage existing installations, research in a great variety of subjects, test new technologies, etc.) which make it difficult to develop common initiatives.
- (d) Most of the consulting engineers are employees who have less control and authority to obtain insurance in the name of the business they work for. They say that it is unfair to deny them a licence to practice on the grounds that they have no insurance, when they as employees have virtually no control over obtaining it.
- (e) The right to practice should not be determined by whether they can get insurance. The insurer who is asked to issue the certificate may base its decision on matters that are not at all related to the competence of the engineer who is applying. The right to review this decision is difficult.
- (f) A certain proportion of the profession never could, cannot now, and never will be able to purchase errors and omissions insurance because of the nature of their activities. A June 1985 survey conducted by APEO indicates that 16% of its 45,000 member association falls into this category.
- (g) At the present time, insurance at affordable rates for many engineers is not available. The June 1985 survey by APEO indicates that 15% (380 firms) in addition to the 16% referred to in subparagraph (f) do not carry errors and omissions insurance because of costs which they say are so high that they threaten the financial viability of the firms.
- (h) Implementation of compulsory insurance would have a devastating affect on employment. The 15% of members who

do not carry insurance because of cost alone represent 380 firms employing 1,500 engineers and 3,500 other employees. APEO estimates that the requirement could threaten over 37,000 jobs.

We cannot, of course, ignore the extensive study of the problem already completed, and the reasons for introducing Bill 123. Because attention has been directed to strictly insurance questions in the limited time available to us, we request that:

- (i) Implementation of Bill 123 be delayed for so long as may be required by some of the associations to look into and to implement self insurance programs. The Ontario Association of Architects, the Ontario Hospital Association and the ten largest accounting firms practicing in Ontario have indicated their intention to study self insurance with a view to setting up their own programs.
- (ii) Further instructions be given to study the compulsory/mandatory question to determine, to what extent and when, Bill 123 should be implemented.

B. PHYSICIANS AND SURGEONS

The physicians and surgeons have a mutual medical defence organization (Canadian Medical Protective Association, CMPA) which is not an insurer. A physician simply joins the Association and as a member, becomes eligible for legal counsel, payment in full of any court award or settlement and payment of costs in any legal action alleging medical malpractice. As well, the association provides sophisticated risk management and educational services that would normally not be provided by a commercial insurance program.

While the Association has been criticized for a perceived reluctance to settle claims, statistics reveal that payments to claimants by way of settlement considerably exceed the number of court awards. By refusing to settle on the basis of economic expediency, however, the association has discouraged nuisance claims against physicians.

At present, we are told that administration costs amount to less than 7% of total revenue. The remaining 93% is available to pay claims and legal fees. This is of course considerably higher than the 58.1% normally available for claims and legal expenses in a traditional general liability policy.

Concern has been expressed that the association does not have a reserve fund, that it relies on annual levies against its members, and that in the future its members will be faced with crisis level levies in order to meet claims.

This is not the case. The CMPA has a well developed actuarially assessed reserve base which is reviewed at regular intervals. Appropriate IBNR allowances are built in using actuarial criteria. CMPA states that it has not been affected by the current insurance crisis. It requires no special assistance in operating its insurance program. It does, however, have a number of special concerns affecting the size of awards, such as gross-up, collateral benefits, limitation periods and OHIP subrogation rights which we deal with in Part III.

C. HOSPITALS

The Ontario Hospital Association (OHA) includes in its membership some 350 hospitals and allied health institutions, including all public general hospitals in the province. Founded in 1924 as an independent, non-profit voluntary organization, OHA provides representation and direct services to assist hospitals to attain the best possible standards of patient care within given fiscal resources.

The affairs of the Association are governed by a 46-member Board of Directors comprising hospital trustees and chief executive officers from the Association's 12 provincial regions.

Hospitals need insurance coverage for many different aspects of their operations. Insurance premium costs are paid by hospitals from the global operating budgets flowed to them by the Ministry of Health.

Hospitals require:

- property insurance (protection of physical facilities and resources);
- boiler and machinery insurance;
- protection for losses as a result of criminal acts;
- liability insurance (protection of financial resources).

Of the different types of insurance coverage listed above, only liability insurance presents particular problems at the present time.

As of March, 1986, 130 public hospitals, or 60%, obtain their insurance, including liability insurance, through the OHA-administered Comprehensive Insurance Program (CIP). The insurer under this program is Scottish and York Insurance Company. Marsh and McLennan Limited is the consultant broker.

The other major supplier of hospital liability insurance is the Guarantee Company of North America, through its broker Frank Cowan Company of Princeton, Ontario.

Major features of the CIP liability coverage are:

- it is an "occurrence" policy, rather than a "claims made" policy;
- there are no deductibles;
- there is no annual aggregate limit on claims.

Most participants in the policy have selected a limit of between \$2 million and \$10 million per occurrence while a few have selected limits as high as \$30 million. This limit applies to both malpractice and general liability.

Participation in CIP is voluntary; each hospital decides whether or not to participate, based on its own situation and the alternatives available in the marketplace. As noted earlier, 130 public hospitals representing approximately 60% of public hospital membership of OHA, and 34 other health care organizations, are currently participating. Of these, 125 public hospitals and 32 other health care organizations hold liability policies under CIP. CIP membership during the last five years has been fairly stable at between 100 and 115 participants. Events of the last 18 months have resulted in a significant increase in the number of participants.

Availability and Premiums

There has been an alarming increase in premiums over the last five years. Hospitals participating in OHA's Comprehensive Insurance Program experienced a 25% premium increase in 1983-84 and again in 1984-85. In 1985-86 the increase was 362% in the basic cost of liability insurance. Because many hospitals also saw the need for higher coverage limits, the actual overall premium increase was 397%. Further substantial increases are expected for 1986-87.

The percentage of the total provincial hospital operating budget spent on liability insurance premiums has risen from an estimate 0.093% or \$3.5 million in 1983-84, to 0.493%, or \$20.5 million, in 1985-86. Projecting for 1986-87, a further 100% increase will take

the figures to \$41 million or 0.947% of the total provincial hospital operating budget.

Ministry of Health allocations have not risen proportionately to take care of the escalating insurance costs. In 1985-86, when premiums increased 397%, the Ministry allocation only increased 3.9%. In that year the total premium cost out of the total allocation was \$94,170,030. Thus it can be seen that insurance costs are having a very major impact on hospital care funding. If it continues, the Ministry allocation will have to increase in real dollars substantially or the standard of health care in Ontario will suffer significantly.

The increase in premiums are the result of increasing frequency and size of settlements and awards. In 1981 there were 11.4 claims per 1,000 beds; in 1986, it will likely be 28.3 claims per 1,000 beds. In 1981 the average claim was valued at \$5,399; by comparison it is expected that the average value of 1986 claims will be \$11,378. Thus frequency has increased more than 2 1/2 times and values of those claims have more than doubled.

It has not been a good time for the insurers. For example, in comparing the premium dollar with value of reported losses, the losses over the last five years have outstripped premium by a minimum of 200%. In 1983 losses were over 400% that of premium. In reviewing reserves it is evident that the insurers either gave too little attention to the real jeopardy or were caught off guard by expanding awards.

As a result, most of the traditional insurance markets have withdrawn. Obviously, the remaining facilities cannot provide all of the coverage required. It is the view of OHA's consultants that "traditional commercial liability insurance markets will not necessarily provide stability, long-term continuity, adequate capacity for competitive placement, nor a willingness to provide the overall quality of protection that OHA's members need".

As a result, OHA is studying other alternatives. One such alternative is to introduce significant deductibles, or a limited amount of self insurance; establish a funded self insurance program with a "catastrophe" insurance policy or additional policies for claims which exceed the limits of the fund; or set up a captive insurer.

Simultaneously, the Canadian Hospital Association is conducting similar studies and coordinating their efforts with OHA with a view to setting up a national facility to include British Columbia, Alberta, Manitoba, Ontario, New Brunswick and Nova Scotia.

As well, a group of Toronto hospitals has commissioned a firm of actuarial consultants to look at the problems facing hospitals in liability insurance and to suggest possible alternative approaches.

The hospitals are obviously taking their insurance problems well in hand and may well come up with a solution. We would however like to make some general comments:

- (a) Because of the hospital's expanding basis of liability it is important for them to provide a comprehensive educational and risk management service to their members. This can best be done by the professionals themselves. Consultants cannot always be expected to have the sensitive awareness of how hospitals operate and where potential jeopardy lies.
- (b) Because hospitals are publicly funded, the choice of a program for the future should be as "lean" as possible. It should be as completely self administered as possible. Every outside participant must make a profit and therefore increases the cost. A successful self administered insurance program should be influential to the Ministry of Health when negotiating annual allocations.
- (c) A reinsurance facility should be provided by the Ontario government on a commercial basis to cover catastrophic losses. Availability and cost precludes going to traditional markets for this coverage at the present. The historical statistics are so bad that it is unlikely that reinsurers will provide catastrophic cover at affordable prices for years to come. If in the future this becomes available at affordable prices, the government reinsurance facility can withdraw. Because hospitals are publicly funded it may not be appropriate (as in the case of architects and engineers) for them to reimburse the government for any losses incurred in the reinsurance program. Such reimbursement would come out of public funds. In any event the public should be prepared to come to the rescue of any hospital that suffers a catastrophic loss. Without such assistance it could likely be closed.
- (d) A number of specific legislative changes should be made to fairly control the size of awards. These are discussed under Part III.

D. ACCOUNTANTS

Chartered accountants who are in public practice can be (for the purposes of insurance) classified into three groups: members who are with the large international firms, members who are practising in small- and medium-sized firms and members who are practising in large domestic firms.

At this time there are basically two approaches to insurance available for the membership. The large international firms have arranged their insurance through a broker, Minet International Professional Indemnity, which looks after their individual needs on an international basis. The policies taken out by these firms have large deductibles and very high limits of insurance commensurate with the size and the possible exposures of these firms.

The small- to medium-sized firms can participate in a Canadian Institute of Chartered Accountants (CICA) sponsored insurance plan. Simcoe & Erie General Insurance Company is the insurer and Reed Stenhouse Limited is the broker. Claims are handled by Simcoe & Erie and F. C. Maltman Adjusting. We understand that the association is content with the service of the insurer and brokers.

Availability and Premiums

The main concern of the small- and medium-sized firms is reduction of coverage to their members. Originally the policy provided \$10,000,000 limits, but this has been reduced to \$1,000,000. We understand that Simcoe & Erie has been unable to find reinsurance above the \$1,000,000 limit because the international reinsurers lump the accountants in with the bad claims experience of international accounting firms in the United States, the United Kingdom and Australia. The reinsurers do not segregate the Canadian experience from international experience, nor do they differentiate between small local practitioners and the large international firms.

Until about a year ago, the CICA sponsored insurance plan was only one of several plans available to the small and medium sized firms. There were about six other competing insurance companies involved. Last year, other competing underwriters such as L. W. Biegler withdrew from the market. We estimate there were several hundred policies issued by these insurers which have not been renewed. Thus the Simcoe & Erie program is the only significant source available to small and medium sized firms in Canada.

It is estimated that 11% of the 3000 small- and medium-sized firms need a minimum of \$10,000,000 limit, and six firms need in excess

of \$10,000,000 to cover normal risks. At the same time, premiums have increased. The CICA estimates that for the reduced \$1,000,000 cover, its members are paying 75% more premium this year.

The small- and medium-sized firms under the CICA sponsored program appear content and seek no assistance.

The large international firms have never been included in the CICA program because the reinsurers have seen their risk as quite different from that of the small- and medium-sized firms. The large firms have written their individual policies through Minets. Their significant concern is limits.

Until two years ago virtually unrestricted limits were available. Some had \$250,000,000 limits. This last year the limits have been reduced to \$50,000,000 for which the insureds are paying four times the premium. At least one of the major firms has been reduced to \$1,000,000 limits, a level simply insufficient for a professional practice with several hundred accountants doing business on an international scale. On renewal the reinsurance limits will be drastically reduced, leaving the large international firms exposed to potentially disastrous losses.

They are working with their broker/consultant Minets to form a self insured Reciprocal. Minets is providing a ten-year claims experience to target problem claims areas.

They may try to arrange a policy written on a five-year basis with a discount or refund paid for every year that the insured remains with the insurer. Exposure above a certain limit will have to be self insured by the Reciprocal.

To make this all possible, the large firms request that tax arrangements be available to establish a reserve with pretax dollars. They cite the experience in Germany where pretax contribution up to \$500,000 may be made to build the reserve. This subject is dealt with in detail in Dr. Slater's report.

But it is the reinsurance above the self insured layer that poses the greater problem. There simply is no market prepared to write reinsurance for accountants at the catastrophic level. Experience worldwide, and primarily in Australia, show that losses in this class can indeed exceed \$150,000,000. Unless a cap on liability is legislated, the government must provide reinsurance at these levels until the reinsurance market is prepared to do so. It may be provided on a commercial basis on condition that any losses sustained would be paid back over a ten-year period.

E. LAWYERS

In 1976 the Law Society of Upper Canada established a group errors and omissions liability insurance program. At present the individual lawyers pay a deductible ranging from \$3,500 to \$10,000; a group self insured layer presently at \$95,000 is provided from levies by the Law Society; an additional \$400,000 is underwritten by American Home; and excess of \$500,000 must be arranged by the individual law firms in the reinsurance market.

In 1981 after the withdrawal of Gestas Inc. as stop loss carrier, the Law Society set up its own inhouse administration which provides full management of the program. Staffed by a Director of Insurance and six claims examiners with considerable prior experience in the insurance industry, the administration operates in much the same way as an insurance company. The director has complete authority on all claims up to \$100,000 and provides copies of reports to American Home with respect to claims between \$100,000 and \$500,000. The administration handles all claims through to conclusion.

We understand that American Home is content with the inhouse administration and with its own results on the program. We also understand that the Law Society is currently paying the lowest professional liability premiums on levies in Canada.

Those levies vary from \$750 to \$3,000 per annum per lawyer, depending on the individual members' claims experience. The following are the categories used to calculate the levy and the deductible per lawyer:

<u>Subscriber</u>	<u>Levy</u>	<u>Per Claim Deductible</u>
Newly Called Member	\$ 1,000.00	\$ 5,000.00
No Claims for 3 to 4 years	900.00	5,000.00
No Claims for 5 years	750.00	3,500.00
One Claim in the Last 3 years	1,150.00	5,000.00
Two Claims in the Last 3 years	1,500.00	5,000.00
Three Claims in 4 years	2,000.00	7,500.00
Four Claims in 5 years	3,000.00	10,000.00

There is however considerable concern about the excess over \$500,000 self administered layer. As discussed above, many of the

significant reinsurers no longer write this business with the result that reinsurance that was readily available to lawyers until January, 1986 is now simply unavailable. For example, Northumberland is in liquidation and Insurance Corporation of Ireland has withdrawn. American underwriters such as New Hampshire continue to write only on a selective basis.

This is so notwithstanding that, according to the information provided by the Law Society, no excess insurer was called upon to pay anything towards claims in the last four years. It is the condition of the world reinsurance liability market that makes this insurance difficult if not impossible to obtain. We understand that reinsurance premiums have increased approximately 400% to 600%. Additionally, we are advised by brokers that for a medium-sized law firm, \$10,000,000 may be the maximum obtainable limits and that the first \$5,000,000 is particularly hard to place.

Lawyers' exposure is not as volatile or large as for example, architects and engineers; nor are they as likely to incur catastrophic losses. It may be that the reinsurers will return to this field in the foreseeable future.

In the meantime, some initiatives have already or should be implemented:

- (a) The Law Society as of July 1, 1986 will increase the self administered limits from \$500,000 to \$600,000 per claim inclusive of defence costs and prejudgment interest;
- (b) The ten largest law firms are forming a self insured Reciprocal with \$50,000,000 limits;
- (c) The Ontario government should provide reinsurance on a commercial basis on condition that all losses are paid back over a ten-year period.

PART III: SPECIFIC PROFESSIONAL LIABILITY ISSUES

A. ALL PROFESSIONS

1. Joint and Several Liability

Where the professional is found liable in negligence, he becomes part of the group of persons who have contributed to the total damage. Under the Negligence Act, all are jointly and severally liable on a 100% basis to the plaintiff. If any member who has contributed to the damages is unable to pay his share, the professional or his insurer must contribute towards the defaulting parties' share until the plaintiff is paid in full. If he is found one percent liable in negligence and no other party has insurance or other funds, he must pay the total judgment. This has the effect of increasing his potential payout, and at the same time encourages claimants to bring in every potential party who might be found at least one percent liable. This in turn results in a multiplicity of parties and escalating litigation expense.

Joint and several liability has particular significance to business professionals like architects, engineers, accountants, and lawyers. In lawsuits against them, the party primarily responsible has gone out of business with the result that the professional and his insurer end up paying an unfair portion of the claim.

2. Concurrent Liability

In recent years the Canadian courts have introduced the concept of concurrent liability. This concept also has particular significance to business professionals. It allows a claimant to sue a professional either in contract on its retainer or in negligence, or both. The duty of the professional in contract is spelled out in the contract retainer and apart from certain implied terms that may be written into the contract, there are no additional terms that may be written into the contract, and there are no duties beyond the four corners of the document. In negligence however, the professional is liable as a member of that professional discipline and his duties are determined by the performance that is expected of a competent member of that professional discipline. Thus, he may be required to warn of defective products that he has not specified, and to warn of incompetent work by contractors over whom he has no control, even though that is not one of the duties spelled out in the retainer contract. For example, in a leading case in British Columbia a Geotechnical Engineer who was retained by the architect was found derelict in his duty for failing to go over the head of

the architect to warn the owner that insufficient bore holes had been taken. This duty was imposed despite the retaining contract which provided a duty only to report to the architect. The result is that the professional is exposed to duties to an ever increasing number of people who are not in direct retainer with him, and he is exposed to even wider duties of performance expected of him as a professional, even where these are not called for in the retainer with his client.

The most serious result of concurrent liability however, is allowing parties who are in a contractual relationship to sue each other in negligence. As soon as the action sounds in negligence, there is joint and several liability under the Negligence Act. Thus, a professional, who until recently was only liable for his own breaches of contract, finds himself also jointly and severally liable in negligence. The result is that the professional becomes responsible for the liability of and therefore responsible to pay up for any of the co-defendants who do not have funds or insurance to pay their share.

We recommend that the concept of joint and several and concurrent liability be further studied. It may be desirable to limit the results of joint and several liability only to claims between parties who are not in direct contractual relationship with each other.

3. Limitations

Lawsuits should be brought within a reasonable time. Certainly at some point, there should be an end to the possibility of litigation in any dispute.

For business professionals like architects, engineers, accountants and lawyers, the problem is that in the last five years concurrent liability has gradually been adopted in actions against them. Until concurrent liability was introduced a professional would be sued in contract by those parties with whom he had a contract. The limitation in contract runs six years from the act that constitutes the breach of contract. That event is fairly easily ascertainable.

In negligence, however, the time starts to run from the date that the claimant was actually aware of the damages that flowed from the negligence, or alternatively, from the date that the claimant being prudent and watchful, ought in the circumstances to have been aware of the damages. This means that the negligent party can be sued many decades after the negligent act provided that the action is brought within six years of the date when the claimant knew or ought to have known of the damages.

Concurrent liability now gives a claimant who is in a contractual relationship with the professional the right to frame his lawsuit concurrently in negligence. Jurisprudence is still unsettled as to whether in these circumstances the time runs from the breach of contract or from the date that the claimant knew or ought to have known of the damages.

This uncertainty means that a professional could be sued in retirement for acts occurring early in his career, and because his errors and omissions policy is on a claims made basis, it has also meant that a professional must maintain his errors and omissions insurance for years after he retires. With uncertainty of this kind, the insurers are unable to set rates today that can realistically account for an insured's exposure at an undetermined time in the future.

For health care professionals, the 1974 Health Disciplines Act introduced the so-called "discovery principles" which allows suit against doctors within one year from the date when the plaintiff knew or ought to have known the facts upon which he alleges malpractice.

As a result, it is now possible for situations to arise in which actions can be commenced against doctors long after the medical services provided have been completed.

British Columbia has recognized this problem and has legislated a special limitation for actions against hospitals and doctors running from the date of the last medical service provided.

We recommend that a similar approach be taken not only for medical professionals but for all professionals. The length of time of the limitation period--be it four years, six years, or even ten years--is not as important as a clear-cut, easily defineable commencement date. The date of the last professional service provided would seem to constitute the most easily ascertainable date, and we therefore would recommend that its use be adopted for this purpose.

4. Prejudgment Interest

While damage assessments as such are not a problem because they are by and large, specific expenses already paid out for loss of profit calculations by accountants, there are some specific items which have increased damage and have affected prior reserves of the insurers.

The most significant of these is prejudgment interest. It begins to run from the date of Notice of Claim and at the rate prevailing one month after the Notice has been served. A rash of Notices were served in the Fall of 1982 when interest rates were at their peak. Interest continued to run from that date at rates in excess of 20%. It is to be noted that these high interest rates followed shortly after the introduction of prejudgment interest in 1978. If adequate reserves were set for prejudgment interest, it would affect the total reserve immediately. If the reserve did not take prejudgment interest into account, the insurers would start to feel the impact about three years later when claims payments would normally be made.

It is interesting to observe that the insurance industry's difficulties surfaced about two years ago, coinciding with the full impact of payments for prejudgment interest.

Some legislative amendments should be made to protect the litigants and their insurers from:

- (a) widely fluctuating interest rates in these unstable economic times, and
- (b) the length of time (over which they have no control) during which litigation slowly unravels and interest continues to run.

While the rate of interest could be left to the discretion of the trial judge, it seems better to set it at a fixed rate, perhaps nine percent. Otherwise, judges could use the rate as a punitive award, and litigants would have one more issue to spend time and money in argument.

The date from which prejudgment interest runs is critical. At present it runs from service of Notice of Claim. Plaintiffs can manipulate the service to coincide with high interest rates, and can delay litigation for years knowing that they can collect interest on the award for the intervening time.

We suggest that a date be set to encourage all parties to determine as quickly as possible within the litigation process the amount of money that they are really fighting over. If interest were to begin to run from the first date on which the defendant could be reasonably expected to know the true value of the claim being made against him, it would encourage all parties to exchange damages information and conclude Examinations for Discovery as quickly as possible.

Normally the defendant would know the true value of the claim being made against him after Discoveries have been completed and medical and expert information has been provided to him, just before the first pre-trial occurs. The court often uses the pre-trial to encourage the parties to discuss settlement, and must therefore be of the view that this is the stage at which the defendant should know the case on liability being made against him and the true dollar value of the damages. Until the defendant knows this, he cannot be expected to settle and pay up. Nor should he have pre-judgment interest running against him before this date.

It is said that the defendant should pay from an earlier date because the insurer has the use of the money and the interest value of it in the meantime. We believe that:

- (a) Interest should not run on a debt until the amount of the debt can be calculated;
- (b) The interest value in the hands of the insurer sits in a lump sum reserve fund that is ongoing. The total interest on the fund is taken into account in settling the reserve for future claims. If it is significant, the reserve amount can be reduced and ultimately future premiums can be reduced. In other words, the interest earned does not find its way into the insurers' pockets as pure profit;
- (c) While interest is running, there is not the same pressure on the claimants to move forward expeditiously with their litigation.

5. Incorporation

Some professionals are not entitled to incorporate. This seems to have been based on the philosophy that a professional performs personal services and should not be allowed to hide behind an impersonal limited liability corporation. Specifically, the accountants, lawyers, doctors and architects cannot incorporate while the engineers can do so. The result is that professionals cannot avoid paying the tax on their earnings by retaining undistributed income within their firms. In each fiscal year, the firms pay out virtually all of their profits to enable the professionals to live and pay their taxes.

If professionals were allowed to incorporate, they could be allowed to retain pre-tax earnings to provide the capital necessary to support much higher deductibles. This would in turn attract the reinsurers because they would see that the insured had a signif-

icant exposure and would likely implement stringent risk management.

We therefore recommend that all professionals be allowed to incorporate.

6. Defence Costs

A great deal of concern has been expressed by all professions about the high cost of legal and adjusting services.

There are several reasons for it.

Concurrent liability and the Negligence Act has resulted in greatly expanded litigation involving every possible contributor to the damages. Manufacturers of products, consultants, contractors and subcontractors, inspectors and construction managers are as a normal course added to the litigation in the hopes that each will be found at least one percent liable. Each of them have different legal duties and each of them are entitled to separate defences. The lawyers defending one party must do so not only against the plaintiff's claim but against the claims for contribution by the co-defendants. Because the duties differ, a number of experts must be retained to study and comment on the performance of the plaintiff, each of the defendants as well as with respect to damages and defective products.

In addition, everyone must keep an eye to the ultimate fund available for payment. Thus each party becomes concerned about the insurance coverage of the other. Insurance denials, defences under non-waiver agreements, exclusions for certain allegations, Mareva injunctions to retain the parties' assets pending litigation and all of the other factors bearing on ultimate payment have become increasingly more complicated. Because there is usually a significant amount of money at stake, everyone vigorously defends their position.

A great deal of time and expense is expended in pre-trial preparation for very long trials. It is not uncommon for trials to take several weeks.

The courts have held that an insurer owes a duty to defend that is completely separate from its duty to provide coverage. In those cases where there is prima-facie coverage, the insurer must provide and pay for a defence even though it has strong grounds for believing that the facts will not ultimately give rise to coverage. And it must provide a defence to each of its insureds involved in the particular claim.

It is not uncommon for an insurer to insure more than one party to a professional liability action. This will certainly be so for architects and engineers now that Simcoe & Erie is by far the major underwriter in that field. Each party is entitled to separate legal representation and a defence to the claims against it. This means that there are a multiplicity of lawyers separately defending each insured and all causing the insurer to incur defence costs.

Where there are insurance issues between the insured and the insurance company, it is now becoming more common to expect the insurer to retain and pay for yet another set of legal counsel to fight out the insurance issues separately from the defence issues.

Thus the multiplicity of issues and parties, the duty to provide separate defences for each insured and the length of trials all results in extensive legal services that make the whole system expensive.

Despite this, insurers regularly make a business decision to pay more legal fees to reduce the claims rather than to fight less and pay more on the claim.

For example, in architects and engineers claims, the large amounts that are at stake almost always lead to full-scale defence with attendant high legal expenses.

The Insurance Bureau of Canada 1984 survey indicates that in general liability the premium dollar is allocated as follows:

Insurance Company:

Internal claims expense	4.8 ¢	
Profit and Contingency	5.0	
Operating Expense	15.3	
Taxes, licences, fees	<u>3.0</u>	28.1 ¢
Brokers Commissions		18.8
Claims and Adjustment Costs		<u>53.1</u>
		100.0 ¢
		=====

National Insurance Managers tell us that claims investigation and defence costs represent 23% of claims payments. If 53.1¢ of the

premium dollar is available for claims payments and defence costs, than 9.93¢ of the premium dollar is spent on legal, adjusting, expert and inhouse claims handling services. If, as we believe, less than 53.1¢ of the premium dollar is available for claims, (see Tracking the Premium Dollar), the legal costs are 23% of a lesser figure.

Legal and adjusting costs are separately set out in the financial statements of each insurer required by the Federal and Provincial Superintendents of Insurance. The results of Federal insurance companies are available on a computer data base. They are broken down only into general liability expenses and do not separately set out those expenses for a professional liability specialty. We recommend that the Superintendent's form be amended to provide more detailed break down of expenses into the various specialties within the general liability field and, in particular, for professional liability.

The Provincial insurer's financial statements are not yet available on a computer data base. We recommend that the form be amended to give the more detailed specialty break down and that this be made available on the computer data base.

We note in passing that it may be misleading to compare legal fees incurred to claims payout. The lawyers are not just fighting those cases in which there has been a payout. They are fighting for the total portfolio of cases to protect the total reserve. The more successful they are, the less the payout will be. Usually success is achieved by very extensive and, therefore, very expensive litigation processes. It would be foolish to use statistics that criticize those lawyers who successfully reduce payout and support those who do little to reduce payout in order to minimize legal costs. It could only be meaningful to compare the lawyer's fees to the true dollar jeopardy that faces the insured. Without legal defence the insured would end up paying that amount. We therefore recommend that the financial statement forms be amended to provide the information required to compare defence costs to total dollar jeopardy.

7. Tracking the Premium Dollar

This is virtually impossible to do for professional liability premiums under present filing requirements. Professional liability financial data is not reported separately from general liability data in the financial filings of the insurers with the Superintendent. This has been discussed above.

In addition to considering insurers filing requirements, the Registered Insurance Brokers Act requires clarification and amendment to include managers and administrators of any professional association programs. This will become particularly important as self insurance programs are established, some of which will undoubtedly retain independent managers.

The financial data should specifically cover professional liability as a class and include in the information:

- (a) Insurance Company or self insurance infrastructure costs, i.e. internal claims expense, profit and contingency, operating expenses, taxes, licences and fees;
- (b) Broker's commissions, including reinsurance brokers;
- (c) External claims and defence costs, including legal, adjusting and expert fees;
- (d) Administrators and managers commissions or fees;
- (e) Claims payout after settlement or adjudication.

We were able to obtain this type information from the Law Society of Upper Canada which administers the insurance program for lawyers (see below). In the present fund year, the Law Society will recover approximately \$11,500,000 of premium dollars. These funds will be disbursed approximately as follows:

Paid to American Home	\$2,000,000
Law Society overhead	640,000
Independent adjusting costs	400,000
Counsel advice	400,000
Defence costs (defence of claims)	3,000,000
Group deductible claims payments	5,060,000

While it is otherwise impossible to provide statistically accurate data, we have gathered some information from which we can reasonably draw some conclusions:

- (a) Because professional liability is more specialized than general liability, as a class it requires more effort to arrange reinsurance and to handle claims. As well, some professions have chosen to engage independent risk

management services rather than doing so through their own organizations. As a result the combined cost of brokers and administrators is somewhat higher. We believe that it exceeds 25¢ of the premium dollar.

- (b) Legal and adjusting fees are also somewhat higher. Although the nature of professional liability claims demand more expensive defences than in general liability, the administrators and associations together with the insurers have worked hard to control the level of costs. We believe legal, adjusting and expert fees (internal and external services combined) total 14.5¢ of the premium dollar.
- (c) The higher broker/administrator and defence costs reduce the balance available for payment of claims. We believe that the balance of the premium dollar available for payment of claims is approximately 42¢. These calculations are based on the insurer's statement that investment income is its only source of profit.

Whether it is possible to improve on these figures remains to be seen. As a first step, however, full disclosure of income and costs is required. Only with this can the professions identify areas of saving and compare alternative coverages.

We note that in the past financial data has been discussed in terms of loss ratios which often exceed 100¢ on the premium dollar. The loss ratios however have built into them profit for various services such as brokers, administrators, adjusters, law firms, etc. This is justified since none of these can be expected to provide services without making a profit. But disclosure of income and costs is a much more meaningful way to assess the comparative value of the product than is a discussion of loss ratios.

B. HEALTH CARE PROFESSIONS

1. OHIP Subrogation Rights

The Ontario Health Insurance Act provides a right of subrogation for past and future medical expenses and requires an injured person to include in his malpractice action a claim on behalf of the Health Insurance Plan.

Once the supplying of health care is recognized as a state activity it could be argued that there is no more reason for an individual

to pay for it (whether he is a receiver of health care or the one who caused the health care to be required) than to pay for any other state activity, except to the extent that he pays taxes.

Following the Monckton Committee Report (Report of Committee on Alternative Remedies Cmd 1946, 6860) post-war British legislation, including the National Health Service, gave up all claim to recoupment. The social welfare system in Britain, as a result, subsidizes all accident prone activities even those that are tortious. By this system, accident losses are distributed over the whole community.

It seems reasonable that the British precedent should be followed abandoning OHIP's subrogation rights and adopting the consequence that costs of health care provided by the state should not be recoverable by either the claimant or the state. This solution accords with recognition of health care as a state activity.

2. "Gross-Up" for Tax on Lump Sum Awards

While this subject is dealt with in detail in Dr. Slater's report, we include information provided to us by the CMPA and the CBAO which considers the whole subject of court awards for personal injuries, taxation and frivolous actions of particular concern to medical malpractice actions.

When the Supreme Court of Canada decided the trilogy it made no allowance for income tax on the income from investment of the awards for personal injury. The position differed from the fatal accident cases where plaintiffs are compensated for the deceased's net, after-tax earnings and an allowance is made for taxes paid on investment income in the hands of the beneficiaries. Although initially the trilogy was taken as laying down a rule that tax was to be ignored in personal injury cases, Ontario courts are now taking the position that such an award falls short of its purpose if it does not include an amount to cover the income tax on the income from the fund. As a result, gross-up is now regularly allowed in Ontario with respect to the component for the cost of future care and prospective loss of earnings. It has been extended to the analogous situation where an allowance is made to a husband for the cost of future housekeeping services in lieu of those which would have been provided by his wife. The practice is not uniform across the country, for as recently as February 10, 1986 in Leischner v. West Kootenay Power, a five-judge court of the British Columbia Court of Appeal refused to allow a gross-up on an award for lost earning capacity.

As Mr. Justice Dickson put it in Andrews v. Grand & Toy:

"The exact tax burden is extremely difficult to predict, as the rate and coverage of taxes swing with the political winds."

As he also said, it requires

"Elaborate calculations...to give an illusion of accuracy to this aspect of the wholly speculative projection of future costs."

The Ontario Court of Appeal, in its recent decision in Nielson v. Kaufman, called the calculation of the gross-up a complex and difficult process, noting:

"it involves not only assumptions with respect to the investments in the fund (e.g. bonds or corporate shares) and the amount of the other income of the recipient of the fund...but also such matters as the present and future federal and provincial tax rates, the range of taxable income to which the rates will apply, and the amount and applicability of exemptions and other deductions."

In the Nielson case, on an award for future pecuniary loss of \$227,237.75, the calculation for gross-up came to \$140,704. The trial judge arbitrarily reduced this amount by a contingency reduction of 25% to \$105,528. The Court of Appeal reduced the future pecuniary loss to \$168,391 and after applying the trial judge's contingency reduction, the gross-up ended as \$71,967, thereby increasing the cost on this head of damage by approximately 43% even after a 25% arbitrary reduction.

The gross-up problem arises from the requirement that courts award a lump sum payment as the present value of a stream of future costs or allowances. The "income" on the lump sum which is taxed is as much a part of the stream of future costs as is the present value. What is required is a recognition that the compensatory payment is in two parts, the lump sum awarded after trial and the periodic payment arising by way of income on that sum. The time has come for recognition of the product of the lump sum (the periodic payment) as part of the award itself, free from tax.

The Department of National Revenue recognizes that where payments for damages have been awarded by a court or resolved in an out-of-court settlement in respect of personal injuries or death, and are paid on a periodic basis, the payments will not be considered to be annuity payments for the purposes of paragraphs 56(1)(d) and 60(a)

of the Income Tax Act and, accordingly, no part of such payments will be treated as interest income (paragraph 13 of Interpretation Bulletin IT-365R). Similarly, the Department recognizes that retiring allowances to an employee, also tax free, need not be by a single payment (paragraph 12 of IT-337R2). Surely the purpose of the receipt should be recognized over and above the time and means by which it arises and be acknowledged in a revised departmental Interpretation Bulletin. If necessary, the original funds (the lump sum) could be segregated and hedged about just as an RRSP or RHOSP so that the taxation authorities will be able to differentiate funds derived from such sources and be assured they are used for the intended purposes.

3. Structured Settlements as an Alternative to Lump Sum Awards

By Section 129 of the Courts of Justice Act, Ontario courts may order periodic payment of certain awards for damages, including awards for personal injuries, but only with the consent of all affected parties.

The advantages of structured settlements, the most common form of periodic payments, are well known. Principally they eliminate the need for gross-up for income tax and remove the need for administration fees, both of which add needlessly to the cost of awards and settlements.

However, Section 129 is deficient in that it does not provide power in the courts to impose structured settlements without consent of the parties. Power in the court to provide for a structured settlement, or its equivalent, without consent of all parties but in the best interests of all parties in the exercise of judicial discretion, is required to effect the full potential of this beneficial innovation.

The result of withholding power from the courts to act without consent of all parties has been that in some cases, particularly in settlement of claims on behalf of infants, annuities have been required by persons acting for them with a guaranteed term certain of long duration (say, 30 years) and with a further provision that if the infant does not survive for the guaranteed period then the payments are diverted to others. Not only do such lengthy periods of guarantee greatly increase the cost, but they mean that monies obtained on the basis that they will be used for future care or other specific purpose may not be used for their intended purpose and constitute a windfall to others. Presumably the courts would not countenance this perversion of the compensation process.

4. Collateral Benefits in Judgments

In 1973 the Ontario Court of Appeal confirmed that a defendant in an action could not take advantage of outside benefits which had been received by a person who had been injured. This ruling has permitted plaintiffs on occasion to receive double recovery under various heads of damage. Mr. Justice Montgomery of the Ontario Supreme Court stated in a recent judgment that the Family Law Reform Act, the pronouncements in the "trilogy" and prejudgment interest all have vastly increased the size of court awards and it is time for the Court of Appeal again to consider the issue of collateral benefits.

Others have commented that the present approach to the problem of collateral benefits is essentially punitive in character and is at odds with the increasing emphasis established by the Supreme Court of Canada "trilogy" on the need to compensate the plaintiff only for his actual loss and provide for his actual needs. Plaintiffs should be prevented from taking advantage of duplication of payments which he or she may have received from other sources, (e.g. disability insurance, welfare payments, re-training programs, etc.).

There should be no overlap between tort compensation and social security benefits. This was the conclusion in the Report of the Pearson Commission (Royal Commission on Civil Liability and Compensation for Personal Injury, Cmnd 7054-I). At paragraph 475 the Commission said:

"We think the time has come for full coordination of the compensation provided by tort and social security. An injured person, or his dependents, should not have the same need met twice, not only because it is inequitable but because it is wasteful. This principle has been adopted in most countries where compensation may be provided through both tort and social insurance".

The recommendation for the elimination of overlap between tort and social security would, the Commission noted, bring about a substantial saving of costs (paragraph 541) and would affect the levels of individual awards (paragraph 542).

By both statute and judge-made law, both before and since the report by the Pearson Commission, the British have been moving to reduce damages for personal injuries by taking into account benefits provided by the state.

5. Discount Rate

In attempting to determine the present value of sums of money to be available in the future, courts in Ontario apply a 2 1/2% per year discount rate. This is intended to represent the difference between the anticipated investment interest rate and the rate of inflation. Many now feel this rate is entirely inappropriate and does not reflect present day inflation rates and anticipated investment income.

Rather than a 2 1/2% discount rate, a 3 1/2, 4 1/2 or even 6% rate could be seen as more realistic.

In a recent Judgment in the Supreme Court of Ontario (McDermid v. Csomor) Mr. Justice Rosenberg allowed a discount rate of 6% in keeping with the realities of inflation and investment income. The discussion of discount rates in the Reasons for Judgment in this action are worthy of consideration.

An example of the impact of the discount rate on awards for personal injury is to be seen in a Judgment in De Champlain v. Yamka. In this Judgment, Mr. Justice Montgomery applied a discount rate of 2 1/2% for the cost of future care of a badly disabled patient. At this rate the total cost of future care amounted to \$1,241,837. If higher discount rates had been applied the amounts would have been as follows:

3 1/2%	-	\$1,026,982
4 1/2%	-	865,284
6%	-	690,099

It is suggested that present discount rates should be reviewed by economic and actuarial consultants to determine if current rates are appropriate. The Rules of Practice should then be amended appropriately.

6. Examination of Legal Aid Procedures

Legal Aid should not lend support to a claimant who has a frivolous cause of action.

More than 50% of the medical malpractice lawsuits with which CMPA deals and which are brought to a conclusion each year are terminated without payment of an award or settlement. It is clear that many of these were without legal merit, something which should have been recognized by the plaintiff relatively early in the course of

the lawsuit. It appears that a significant number of these cases are prolonged unnecessarily because the plaintiff insists on continuing at no financial cost to himself and legal aid authorities authorize this continuance. When ultimately the plaintiff discontinues an action which has no legal merit, it is futile to attempt collection of costs because the plaintiff is impecunious.

Legal Aid has discretion to pay such costs and attempt to recover them from the plaintiff, but this discretion is only exercised where the defendant has personally suffered financial hardship. Of course, this cannot be demonstrated where the CMPA is defending the doctor.

We recommend that where Legal Aid allows a claimant to continue an action against a physician, Legal Aid should be responsible for payment of any costs awarded against the unsuccessful claimant.

In addition, we recommend that the Rules of Practice be amended to allow the court to direct the filing of security for costs against a plaintiff who resides within the jurisdiction in appropriate cases. At present, the only remedy against a resident plaintiff is an order striking out the action if it is frivolous. Since this deprives the plaintiff of his day in court, the order is issued only in the clearest of cases. Where the court has concern that the case may be frivolous it should allow the case to proceed only if after dismissal, the claimant has the ability to indemnify the defendant for his costs. An order for security would achieve this.

7. Family Law Legislation

This subject has been addressed in other submissions to the Task Force. The general concerns can be summarized as follows:

- (a) The effect of the legislation is to increase the potential group of unknown claimants;
- (b) Where there is an award or settlement in favour of a partially or totally disabled plaintiff, this legislation can result in "double compensation" to the plaintiff's relatives, already compensated under the legislation, who inherit the balance of the award or settlement upon the plaintiff's demise.

As to the second of the above concerns, we recommend that amendments be considered to effect a similar system to that under the Workers' Compensation legislation whereby expense benefits cease upon the injured worker's demise.

8. Hospital Liability

Traditionally, hospitals have not been liable for a physician's negligence if the physician was an independent practitioner and not an employee in the usual master and servant relationship.

There is a clear trend towards imposing "corporate liability" on the hospitals for the negligence of the medical or dental staff regardless of any employer/employee relationship. In the Ontario case of Yepreman vs. Scarborough General Hospital, Mr. Justice R. E. Holland found the hospital liable for the negligence of an independent physician on its specialty medical staff. The hospital provided an emergency department and a roster of general and specialist physicians to be available for the medical care of any patients who were presented. This patient did not choose the physician. The physician was found by the court to have been clearly negligent. On appeal, the higher court overturned the trial judgment by a 3 to 2 decision. Although this result left the traditional law in place, it shows that six Ontario Supreme Court justices were split 3 to 3 on the issue. The case was settled out of court in favour of the plaintiff and thus not allowed to go to the Supreme Court of Canada.

A current Statement of Claim filed June 1985 with the Registrar of the Supreme Court of Ontario, alleges among other things that the several physician defendants are hospital employees or, if not, the hospital is vicariously liable because the patient did not choose the physicians who cared for him, and that they were an integral part of the organization of the hospitals providing services which the public as a whole and this patient in particular expected from the hospital.

This notice of corporate liability essentially began in the United States through a judgment by the Supreme Court of Illinois, September 1955 in the case of Darling vs. Charleston Community Memorial Hospital. An eminent Manitoba judge wrote of the importance of the case in the October 1970 issue of Canadian Hospital. In OHA Report on Legislation No. 233 November 5, 1970 on this article about the Darling case, the following appeared:

Hospitals are no longer seen as passive parents who only provide facilities.

The court, in the case referred to, quoted from an opinion by a New York court as follows:

"The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to

procure them to act upon their own responsibility, no longer reflects the fact. Present day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment."

This, therefore, makes the case that much more deserving of careful study and application. Although the law and legal procedures in the U.S.A. differ in some respects from those in Canada, the basic facts in this case relating to the responsibility of the hospital, cannot be overlooked.

Some specialists in hospital laws advise us that if corporate liability is not in fact here in Ontario, it is on the immediate horizon and that this view is held by medical liability insurers.

We note that Mr. Justice Dubin in the Dubin Report on the Hospital for Sick Children expressed his personal opinion that there should be statutory changes to make hospitals liable for the practice of medicine by physicians in a hospital.

Clearly the courts are moving towards corporate liability for the hospitals.

This has a profound impact on insurance. Without corporate liability the negligence of independent doctors affects only the CMPA. If corporate liability is imposed, the negligence of independent doctors will also affect the hospital's insurance program. Whether we are to have hospital corporate liability or not should be resolved. It cannot be resolved fairly without hearing from all those who may be affected, including the CMPA, the OHA, the Dental Association, insurers, etc.

We recommend that action be taken to remove the uncertainty by legislation after appropriate study.

PART IV: LIST OF RECOMMENDATIONS

1. Government sponsored commercially based reinsurance facility for self insured programs. (pp. 12, 25 32)
2. Amendments to financial reporting requirements. (pp. 46-48)
3. Further study of mandatory/compulsory insurance requirements. (p. 14)
4. Tax amendments to accelerate reserve buildup of self insured programs. (p. 29)
5. The concept of joint and several and concurrent liability should be further studied. (p. 35)
6. The limitations period for all professionals should commence to run from the date of last professional service. (p. 38)
7. Prejudgment interest rates should be fixed and commence to run from the first date on which the defendant could be reasonably expected to know the true value of the claim being made against him. (p. 40)
8. Professionals should be allowed to incorporate. (p. 42)
9. OHIP's subrogation rights should be abolished. (p. 51)
10. Gross up should be modified. (p. 54)
11. The court should be empowered to impose structured settlements even where it does not have the consent of the parties. (p. 55)
12. There should be no overlap of tort compensation and social security or other collateral benefits. (p. 56)

13. Present discount rates should be reviewed by economic and actuarial consultants and revised if appropriate. (p. 59)
14. Legal Aid in some circumstances should be responsible for third party cost awards. (p. 60)
15. The Rules of Practice should be amended to allow an order for Security for Costs against resident plaintiffs in some circumstances. (p. 60)
16. Amendments to the Family Law Legislation should be made. (p. 61)
17. The issue of hospital corporate liability should be studied and resolved. (p. 64)

APPENDIX 11

Report
to the Task Force on Insurance
on the
Ontario Private Passenger Automobile Bodily Injury Claims Study
(IBC Data Base)

April 17, 1986

The Wyatt Company
and
Cassels, Brock & Blackwell

I. Requirements of Task Force

The general insurance industry in Ontario has argued that both price increases and decreases in capacity result, in large part, from increases (over and above inflation) in the costs of claims arising from bodily injury (whether automobile-related or otherwise). The industry position is that such increases can be explained by two broad factors:

- increases in the amounts awarded over time for general damages in respect of comparable injuries
- the addition of new categories for recovery of costs (and increases in the amount awarded within such categories), i.e., introduction in 1977 of a statutory entitlement to pre-judgment interest and in 1978 of dependant's claims.

In support of its position, the industry points to certain court judgments, to legislative changes and to its general underwriting losses. This evidence, however, does not prove that there is any causal relationship between the factors described and the worsening loss experience. As a result, the Task Force requested that research be undertaken for the purpose of establishing, statistically, the causation and extent of the increases.

II. Sources of Data

While many court judgments are included in published reporting services, such judgements represent only a fraction of claims made. Very few claims actually are resolved by a court, and not all of those are reported (usually only cases of precedential value are reported). Reported cases do have a "multiplier effect" because court awards influence out-of-court settlements in similar cases. A study of reported cases, therefore, would be of very limited use in analyzing bodily injury claim results because of the relatively small number of cases involved and the difficulty of identifying comparable cases.

One of the major reasons why court awards have a "multiplier effect" is that there are publications which, on a periodic basis, list of the quantum of general damages for any given injury (see, for example, Goldsmith's Damages for Personal Injury and Death in Canada). Such comparisons are not cumulative and they do not include information on other bases for recovery, e.g., pre-judgment interest.

The sources designed for use by lawyers in pursuing bodily injury claims, therefore, are not appropriate for establishing statistically the relationship between damages and losses. The only other body of data on claims is that maintained by the Insurance Bureau of Canada ("IBC").

All private insurance companies are required to report automobile premiums and claims experience to the IBC according to the statutory Automobile Statistical Plan.

The IBC compiles these submissions and produces various reports and exhibits which are used by the insurance industry.

However, the data base maintained by the IBC does not categorize claims information by type of injury nor provide a breakdown of the components of claim payments (eg. general damages, Family Law Reform Act payments, etc.)

This information is only available in the individual claim files themselves.

Therefore, it was decided to request access to actual claim files in large insurance companies with the objective of determining the influence of various factors on rising insurers' claim costs over an eight year period (1976-1984).

III. Methodology

The IBC provided a listing of all private passenger automobile claims larger than \$1,000 experienced by five major insurance companies, selected by us, allocable to policy years 1976, 1980 and 1984.

Rather than proceeding directly with an investigation using claims experience from the five companies, one was chosen to provide assistance as a pilot project.

Consequently, 150 claim numbers from each of policy years 1976, 1980 and 1984 were selected, including from each year, 75 claims larger than \$50,000.

The company made available claim files corresponding to the selected claim numbers to an experienced lawyer for detailed analysis using a questionnaire created for this purpose (see exhibit I).

The information from completed questionnaires was compiled into a data base, producing the results shown in Table 3.

IV. Results and Recommendations

The following tables are attached.

Table 1:	IBC Size of Loss Distribution - Bodily Injury Claims (Ontario) - Valued at December 31, 1984
Table 2:	Data for Five Companies
Table 3:	Sample Company Analysis
Table 4:	Development of 1984 Policy Year Data

Three significant factors affecting the outcome of the study should be noted:

- a) Insurers generally and the company studied in particular, have implemented file destruction procedures for closed files. As the bulk of claim files for 1976 are closed, the bulk of those files have been destroyed. Very few open files remain. Tables 2 and 3 therefore are based only on the 1980 and 1984 policy years. The study therefore is missing its "anchor" in 1976, a year pre-dating certain statutory changes discussed above.
- b) The claims for the 1980 policy year are reasonably well-developed but many claims in the 1984 policy year are yet to be settled. While the average claim size (Tables 1 and 2) appears to be relatively constant between 1980 and 1984, the 1984 experience is understated due to the fact that no estimate is included of claims which have occurred but are not yet reported and future development on claims that have been reported. This development is approximated and a comparison of 1980 with 1984 is shown in Table 4.
- c) The 1980 policy year claim files generally did not include a breakdown of the final settlement figure, preventing comparison of the amounts for 1980 to the 1984 amounts (Table 3, "Claims Allocation By Component").

The study, therefore, suggests that it is impossible to prove statistically: a) whether general damages for comparable injuries have increased losses and, if so, at what rate; and, b) to what extent new categories for recovery have increased losses. Even if an adequate number of claims for the 1976 policy year were available, the study shows that it is unlikely that the total settlement figures would be broken down with sufficient particularity to allow comparison through 1976, 1980 and 1984. We are of the opinion that the amount of detail available from the files is unlikely to be any more satisfactory in any other company or companies because the industry has reasonably consistent practices.

The study does highlight several matters:

1. Increase in Average Claim Size - Industry - Table 1

	<u>Increase in Average Claim Size</u>	<u>Increase in Consumer Price Index (2)</u>
1976/1980	46.2%	41.4%
annualized	10.0%	9.0%
1984/1980 (1)	43.1%	37.7%
annualized	9.4%	8.3%

(1) 1984 claims have been adjusted to reflect future claims development (see Table 4).

(2) The increase in CPI is based on information produced by Statistics Canada.

This chart shows that the average third party liability claim has increased by about 7% more than the Consumer Price Index during 1976-1984.

2. Variance in Average Claim Size - Five Companies - Table 2

While the five company total average claim size corresponds well with the total industry's average, there is much variation within the five. This variation might be the result of many factors such as variation in

- claims management and methods
- marketing and underwriting emphasis
- chance fluctuations.

3. Sample Company Analysis - Table 3

a) There appears to have been a fair degree of consistency between 1980 and 1984 in the types of injury in proportion to the total number of claims.

b) The "Legal Process" portion of Table 3 for policy year 1980 shows that it is usual for a claimant to have a lawyer. Legal actions were initiated only in 32% of the 1980 claims under \$50,000, although that figure rose to 100% for claims over \$50,000. Only 2% of the claims under \$50,000 had reached trial by March 1986. None of the claims over \$50,000 had reached trial by March, 1986. The experience and ability of the lawyer for the claimant can be a factor in increasing the amount of the claim over and above the norm. Innovation is more likely to occur in the larger claims.

c) Only 45% of the claims under \$50,000 are handled expeditiously by the claimant, while that figure drops to 22% for the claims over \$50,000. Similarly, adequate and timely disclosure to the insurer is more likely to be made in the smaller claims (75%) than in the larger claims (44%). Interestingly, the insurer, in our judgement, made a reasonable and timely offer to settle in 68% of the cases under \$50,000 (adequate and timely disclosure having been made in 75% of those cases). It should be noted, however, that advance payments are used by the insurer only in a small percentage of cases.

d) Comparing the 1980 and 1984 policy years on page 2 of Table 3 should be done while remembering that there are 1984 claims unreported at December 31, 1984 (most likely, claims over \$50,000).

In summation, this study has shown that it is not possible, due to lack of detailed historical information, to identify the legal factors driving the increases in claims costs and to show their effects statistically.

EXHIBIT I
CLAIMS CHECKLIST
(Per Claimant)

General:

Claim Number:	_____	Company Number:	_____
Policy Year:	_____	Territory:	_____
Accident Date:	_____	Policy Limit:	_____
Total Claim: Paid	_____	Claim: Open	<input type="checkbox"/>
Reserve	_____	Closed	<input type="checkbox"/>
Total	_____		

Type Of Injury:

Soft Tissue: <input type="checkbox"/> 1. (3 month disability)	Knee	<input type="checkbox"/> 2.	Back	<input type="checkbox"/> 3
	Psychic Trauma	<input type="checkbox"/> 4.	Catastrophic Injury	<input type="checkbox"/> 5.

Allocation by Component:

	<u>Amount</u>		<u>Amount</u>
1. General	_____	5. P.J.I.	_____
2. Special (excl.wages)	_____	6. Legal Costs	_____
3. Wages	_____	7. Other Costs	_____
4. F.L.R.A.	_____	8. Gross Up?	_____

Has there been adequate and timely disclosure made to allow the Insurer to commence payment? Yes ☐ No ☐

Process:

1. Lawyer?	Yes <input type="checkbox"/> No <input type="checkbox"/>	4. Location of Trial	_____
2. Action Commenced:	Yes <input type="checkbox"/> No <input type="checkbox"/>	5. Judge <input type="checkbox"/> Jury <input type="checkbox"/>	
3. Trial?	Yes <input type="checkbox"/> No <input type="checkbox"/>		

**CLAIMS CHECKLIST
(Per Claimant)**

Insurance Company Initiatives:

- | | |
|---|--|
| 1. Reasonable and timely offer to settle? Yes <input type="checkbox"/> No <input type="checkbox"/> | 3. Structured Settlement Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Advance Payments? Yes <input type="checkbox"/> No <input type="checkbox"/> | 4. Delay Tactics? Yes <input type="checkbox"/> No <input type="checkbox"/> |

Claimant Action:

1. Is there evidence of collateral benefits? Yes ☐ No ☐
- If yes, what type?

2. Was claimant's solicitor a factor in amount of settlement? Yes ☐ No ☐
- If yes, positive ☐ negative ☐

3. Was there any evidence of innovation? Yes ☐ No ☐
- If yes medical ☐ legal ☐

1. Was claim advanced expeditiously? Yes ☐ No ☐
2. Did the New Rules have any effect on outcome? Yes ☐ No ☐
- If yes, describe

General Remarks:

ONTARIO PRIVATE PASSENGER AUTOMOBILE
BODILY INJURY LIABILITY CLAIMS STUDY
VALUED AT DECEMBER 31, 1984

TABLE 1: INDUSTRY DATA LOSS DISTRIBUTION

Size of Claim	1976		1980		1984	
	#	Avg.	#	\$	Avg.	\$
1,001 - 5,000	9,479	26,342,102	12,754	38,024,818	2,981	13,185
5,001 - 10,000	3,005	23,258,209	5,318	41,557,976	7,815	7,008
10,001 - 25,000	1,808	30,503,676	3,986	66,358,414	16,648	4,880
25,001 - 50,000	607	22,365,862	36,847	45,600,950	37,256	1,236
50,001 - 100,000	271	19,585,416	72,271	43,797,493	74,740	458
100,001 - 250,000	85	10,991,140	129,307	40,315,449	143,984	170
250,001 - 500,000	26	7,910,751	304,260	41,203,921	302,970	127
500,001 - 1,000,000	1	563,174	563,174	12,293,030	614,652	34
over 1,000,000	0	0	0	0	0	4
Total	15,282	141,520,330	24,304	319,152,051	13,543	27,102
# cars insured						3,782,117
# claims/1,000 cars insured	2,863,082		3,420,996			7.17
	5.34		7.11			

NOTES: 1. All data is based on information supplied by Insurance Bureau of Canada (IBC).

2. Data does not include any estimate for future loss development (this will have greatest impact on 1984 year). See Table 4.

3. Claims are valued at December 31, 1984 (June 30, 1985 close off).

**ONTARIO PRIVATE PASSENGER AUTOMOBILE
BODILY INJURY LIABILITY CLAIMS STUDY**

TABLE 2: DATA FOR FIVE COMPANIES

COMPANY	1976 POLICY YEAR ONTARIO CLAIMS > \$1,000			1980 POLICY YEAR ONTARIO CLAIMS > \$1,000			1984 POLICY YEAR ONTARIO CLAIMS > \$1,000			
	Claims Incurred	Approx. Number of Claims	Average Claim	Claims Incurred	Approx. Number of Claims	Average Claim	Change in Average Claim 80/76 Annualized	Claims Incurred	Approx. Number of Claims	Average Claim
1.	\$8,170	825	\$9,910	\$15,027	1,075	\$13,980	41.1%	\$15,790	955	\$16,535
2.	15,898	1,780	8,925	38,058	2,540	14,985	67.8%	34,728	2,490	13,945
3.	6,927	865	8,010	13,091	1,360	9,625	20.2%	17,394	1,720	10,115
4.	3,445	380	9,065	11,665	700	16,665	83.8%	16,648	1,300	12,805
5.	16,741	1,425	11,750	36,988	2,590	14,280	21.5%	13,094	1,090	12,015
TOTAL:	\$51,181	5,275	9,700	\$114,829	8,265	\$13,695	43.2%	\$97,654	7,555	\$12,925

NOTES:

1. No factors applied for OHIP, future development etc. but includes claims expenses and reserves.
2. Data supplied by the IBC on a CONFIDENTIAL basis.
3. The five companies represented about 32% of the Ontario private automobile market in 1984.
4. All data is valued at December 31, 1984 (June 30, 1985 close off).

**ONTARIO PRIVATE PASSENGER AUTOMOBILE
BODILY INJURY LIABILITY CLAIMS STUDY**

TABLE 3: SAMPLE COMPANY ANALYSIS

	<u>1980 POLICY YEAR</u>		<u>1984 POLICY YEAR</u>	
	<u>Under \$50,000</u>	<u>\$50,000 and Over</u>	<u>Under \$50,000</u>	<u>\$50,000 and Over</u>
<u>AVERAGE CLAIM IN SAMPLE</u>	\$7,343	\$110,962	\$8,300	\$113,840
<u>NO OF CLAIMS ANALYZED</u>	44	9	93	26
<u>CLAIMS ALLOCATION BY COMPONENT</u>				
1. General	N/A	N/A	69%	35%
2. Special			3%	-
3. Wages			11%	26%
4. F.L.R.A.			3%	18%
5. P.J.I.			2%	10%
6. Legal Costs			11%	11%
7. Other Costs			1%	-
8. Gross Up			-	-
<u>TYPE OF INJURY</u>				
1. Soft Tissue	89%	56%	84%	54%
2. Knee	9%	33%	11%	35%
3. Back	34%	56%	38%	15%
4. Psychic Trauma	5%	22%	8%	12%
5. Catastrophe	0	-	0	15%
6. Fatality	0	11%	3%	12%

TABLE 3: Continued

	<u>1980 POLICY YEAR</u>		<u>1984 POLICY YEAR</u>	
	<u>Under \$50,000</u>	<u>\$50,000 and Over</u>	<u>Under \$50,000</u>	<u>\$50,000 and Over</u>
<u>LEGAL PROCESS</u>				
1. Lawyer?	82%	100%	71%	85%
2. Action?	32%	100%	18%	62%
3. Trial?	2%	-	-	-
4. Solicitor a factor?	55%	78%	15%	19%
5. Innovation?	-	11%	-	4%
6. Expeditious?	45%	22%	48%	31%
7. New Rules Affected?	5%	-	2%	4%
8. Adequate and Timely Disclosure to Insurer?	75%	44%	58%	46%
<u>INSURANCE COMPANY INITIATIVES</u>				
1. Reasonable and timely offer to settle?	68%	33%	66%	31%
2. Advance Payments?	14%	11%	5%	23%
3. Structured Settlements?	2%	-	-	-
4. Delay Tactics?	-	-	-	-
<u>EVIDENCE OF COLLATERAL BENEFITS</u>	11%	-	8%	19%

**ONTARIO PRIVATE PASSENGER AUTOMOBILE
BODILY INJURY LIABILITY CLAIMS STUDY**

TABLE 4: DEVELOPMENT OF 1984 POLICY YEAR DATA

	<u>Number</u>	<u>Amount</u>	<u>Average</u>	<u>No. of Claims/000 Cars Insured</u>
1984 (no development - at 18 months maturity)	27,102	344,832,268	12,723	7.17
Factor used to bring to same maturity level as 1980 (66 months)	1.095	1.668	-	-
1984 (developed - to 66 months maturity)	29,677	575,180,233	19,381	7.85

The factors used were derived from the 1984 Green Book using Ontario selected private passenger BIPD factors to move from 18-30 and 30-42 months maturity and countrywide BIPD factors to move from 42-66 months maturity.

	<u>Losses</u>	<u>Claims</u>
18-30	1.351	1.097
30-42	1.154	1.000
42-66	1.070	.998
	-----	-----
18-66	1.668	1.095

APPENDIX 12

THE QUEBEC AUTOMOBILE INSURANCE SYSTEM

In March 1978, Quebec introduced a new Automobile Insurance Act that completely abolished the fault system for the compensation of automobile accident victims for bodily injury. The system is publicly administered by La Régie de l'assurance automobile du Québec.

Insurance coverage takes two forms: a basic compulsory public plan and a supplementary elective private plan to provide no-fault insurance for those who do not believe themselves to be adequately covered by the basic plan. The basic plan pays unlimited indemnities for medical and rehabilitation costs not covered by other public plans, and limited amounts for injuries, dismemberment, and pain and loss of enjoyment of life. There is a maximum indemnity (which was estimated to compensate the total loss of income of 85% of the population in 1978) for disability and death benefits. The indemnities are paid in the form of indexed annuities, after a waiting period of one week (a type of deductible in order to eliminate minor claims and, then, to reduce premiums). Annuities are not taxable and the maximum paid to an individual represents 90% of his net income up to a maximum gross income (\$18,000 in 1978 and \$33,000 in 1985); that is, the total net income less the expenses inherent in going to work. The compensation table for accidents in Quebec (1985) is attached herewith.

Persons at home, unemployed persons, retired persons, students and minors receive income replacement benefits even if they are not in the work force. In case of death due to automobile accidents, the regime pays funeral costs up to a certain maximum as well as compensation whether or not a person supports a family. However, the levels of compensation are not the same in both cases.

These plans are in lieu of all rights: no action is permitted before any court of law. A claimant who disagrees with the decision of the officer of La Régie concerning compensation may apply to La Régie to have the decision reviewed.¹

The pricing of the insurance in the basic plan involves a set premium for a given class of vehicle regardless of the risk represented by the individual, his past experience and so forth. Since March 1983, however, a driver without demerit points and criminal infractions over the previous two years is eligible for a discount of \$5 on the renewal cost of his driver's licence. The main sources of financing are fees for drivers' licences and automobile registration fees. A tax on gasoline was used before March 1982. Another source of funds is interest revenues.

Quebec also opted for a system of partial no-fault insurance for property damage. This remains administered by the private industry, specifically the Groupement des assureurs automobiles - a consortium of private insurers established by legislation.

¹ There is then a right of appeal to the Commission des affaires sociales, whose decision is final.

Under this system individuals are required to purchase insurance for damage to property. This insurance provides coverage for the driver's damage to vehicles other than automobiles and compensates the driver who is not at fault for his vehicular damage. The fault is determined by a schedule of typical accident situations. The driver who is at fault compensates the driver who is not at fault for his vehicular damage. The driver who is at fault is compensated for his losses only if he purchased voluntary collision coverage. Drivers who are at fault will incur the loss of the deductible if they have collision and will pay the entire cost if they have no collision coverage.

The property damage provisions eliminate third-party compensation for vehicular damage. They provide coverage for one's own damages, depending on a simplified fault determination process. This system is similar to the Ontario system for those with collision insurance, provided there are no injuries. In Ontario two insurance companies will deal with collision claims in much the same way as in Quebec. The difference occurs for those without collision coverage. In Ontario the individual would have to bring his own claim against the other person's insurance company if he is not at fault. In Quebec one's own insurance company would provide benefits based on a simplified fault system. As Sam Rea notes, the costs of obtaining compensation should be lower in Quebec for those not at fault (and without collision insurance).

(In both provinces, insurance premiums are based on claims experience and traditional risk classifications such as age, sex, marital status, territory, type and use of cars.)

Pursuant to the Direct Compensation Agreement all insurers have waived subrogation rights among themselves except in some unusual situations. And a dissatisfied insured may have legal recourse only against the insurer in compliance with standard rules and procedures. This may involve an Arbitration board of the Groupement, the decision of which is final.

This quantum leap in the basis for personal injury and property damage compensation was not taken precipitately. In 1973, the Gauvin Committee of Inquiry on Automobile Insurance concluded that under the then existing fault/tort regime, 28% of individuals who suffered economic losses were not compensated and victims who were not at fault received a maximum of 60% compensation for economic losses (p. 200). The Committee also emphasized long delays before compensation was paid out. Finally, the high administrative costs were deemed unacceptable and excessive. Total administrative costs, including selling expenses (agents' commissions), underwriting and policy processing and general administrative costs represented 34% of premiums, compared to only 16% in Manitoba for the same period.

Ultimately, the new Parti Québécois government accepted the main recommendations of the Gauvin Committee with one important addition: basic insurance for bodily injury is managed by a single state-owned company - La Régie. It is appropriate now to review briefly the advantages and disadvantages of the Quebec system with the benefit of eight years experience.

A recent study of the Quebec system has been prepared by two University of Montreal professors: "L'Assurance automobile au Québec: Bilan d'une Réforme" by Claude Fluet and Pierre Lefebvre (February 1986). This is attached as Appendix 13. It would be useful to highlight their findings.

In general, the authors conclude that the record of the Quebec automobile insurance system has been positive: the overall protection has been increased, the appreciable efficiency gains have allowed the relative cost to diminish, and the quality of the compensation procedures has improved significantly. Indeed, in retrospect it seems that the three fundamental choices made by the government in establishing the regime (the total abolition of tort actions and the notion of fault, limits on recovery for non-pecuniary losses, and the public administration of the regime) have been justified.

With specific reference to the no-fault bodily injury system, the following observations are most pertinent:

- o Since 1978, the public regime has collected 93% of total insurance premiums and distributed 97% of net compensation payments. The residual part provided by the private sector relates to supplementary private disability and special coverage in respect of accidents outside Quebec.
- o The proportion of automobile accident victims receiving compensation has increased by 20% from 41% to 50%. Almost all severely injured victims are totally compensated.
- o The delays in compensation have been considerably reduced: under the old regime, 65% of victims had received no compensation 6 months after the date of the accident; under the new regime, this is down to a mere 4%.
- o The compensation level per victim has risen approximately 14% under the new system. Taken together with an increase in the frequency of compensation of some 18%, this represents an increase of 35% per victim.
- o The relative cost of insurance (including administrative costs) per dollar of compensation has significantly diminished, from 1.63 to 1.13. And the relative price of insurance has diminished in the same proportions. This reduced cost is explained in terms of the abolition of the fault principle, and the consolidation of administration in a public body.
- o Comparing the period 1973 to 1977 with that of 1978 to 1984, the ratio of expenses to net compensation has been reduced by 4% for property damage and by 36% for bodily injury, for a total reduction of 15%.
- o Insurance premiums have risen in real terms between 1978 and 1984. The average premium for bodily injury increased by 1.5%, and the average premium for property damage by 6.7%.

The study also set out a comparison of the Quebec regime with the regimes in Ontario, Manitoba, Saskatchewan and British Columbia. Its findings suggest, among other things, that the portion of the premium dollar returned to the insured in Quebec is much higher than in Ontario and somewhat higher than in the western provinces.

This brief discussion of the Quebec model should include a brief assessment of the experience with the property damage regime since 1973. In this connection, Fluet and Lefebvre make the following observations:

- o The new law has not had a significant effect on the number of insurers carrying on business in Quebec. For example, the five largest insurers still account for about 35% of the market.
- o There has been an increase in the number of vehicles insured (from 90% to 98%).
- o The return to the insured, measured by ratio of net compensation to premium has increased from 58% in 1973-1978 to 67% in 1979-1984. The inverse ratio - premiums paid per dollar of net compensation - has fallen from 1.74 in 1973-1978 to 1.50 in 1979-1984 - a reduction of 14.3%.
- o There has been a small reduction in the ratio of cost d'exploitation/total expenditures from a 38% average in 1973-1978 to 34% in 1979-1984. This is an indication of the increased efficiency of the new system. More specifically, a little more than half of this reduction in the relative price of property damage insurance can be attributed to a reduction in the ratio of premiums to total expenses, while a little less than half can be attributed to the reduction of the ratio of total expenditures to net compensation.

In conclusion, the Quebec experience with a no-fault, no-lawsuit automobile insurance system for bodily injury compensation, and a rather unique partial no-fault regime for property damage, appears to be generally positive. Virtually everyone consulted by the Task Force in Quebec commented favourably on the system, whether they were beneficiaries of the system, or from within government, the insurance industry, and even the legal profession itself.

The main focus of criticism has been on the failure to devote more resources to safety education and to strengthen the very weak bonus-malus system whereby a driver with good experience is entitled to a mere 4% reduction on his annual premium. These areas are now apparently receiving much greater attention.

In addition, there is concern that the compensation levels are inappropriate: too rich for some, while inadequate for victims such as young professionals at the beginning of their working career. In this connection, La Régie is in the process of preparing a proposal to rebalance the compensation levels. It should be noted parenthetically that the compensation levels for workers are now fully integrated with that of the workers' compensation scheme.

The other area where change may be anticipated is in respect of the possible privatization of some of the functions of La Régie. Although most observers are generally complimentary of La Régie's operations, particularly in respect of its efforts at rehabilitation and so forth, most private insurers believe that the private sector could deliver the services more efficiently and effectively, and could provide the consumer with greater choice in terms of the type of disability insurance package he or she might want to purchase. It must be noted, however, that none of the proponents of privatization recommend a return to the tort system in any way, and they fully expect the government to continue to mandate minimum compensation levels.

Finally, with respect to property damage, once again there is general agreement that the direct compensation, no-subrogation system is more efficient and is working well. Some modification to the structure of the Groupement des assureurs has been mooted insofar as its activities overlap with those of the Quebec Branch of the Insurance Bureau of Canada, but this is not a major bone of contention.

Compensation tables of La Régie de l'assurance automobile du Québec for accidents in Quebec between January 1st and December 31, 1986.

I Bodily Injury

A. Income Replacement Indemnities

Category	Compensation Amount ¹	
	Maximum	Minimum
1. Full-time workers	90% of net income ²	\$145.31 + \$18.17 per dependent up to a maximum of \$254.33 per week
2. Persons without full-time employment but able to work	90% of net income ² derived from gross income established by La Régie	\$145.31 + 18.17 per dependent up to a maximum of \$254.33 per week
3. Persons at home (or may opt for compensation under category 2)	\$272.45 per week for expenses incurred as result of the accident (e.g., home care, support)	
4. Persons unable to work for reasons other than age	\$145.31 + \$18.17 per dependent up to a maximum of \$254.33 per week	Idem
5. Persons under 16. When they reach 18, if still unable to work	\$145.31 per week \$215.76 per week	Idem Idem
6. Students 16 or over enrolled in a secondary or post-secondary school full-time		
(a) With a well-paying job	90% of net income ²	\$145.31 per week
(b) Without a well-paying job	\$145.31 per week	Idem

¹ In the case of the income replacement indemnity, the pensions are decreased by the amounts of the disability pension and pension for children of disabled contributors payable under the Quebec Pension Plan or a similar plan outside Quebec. The pensions are also decreased by old-age pension amounts when beneficiaries reach the age of 65.

² The net income is established by subtracting from the gross income federal and provincial taxes, unemployment insurance contributions and Quebec Pension Plan contributions. The maximum gross income admissible is \$33,000.

I Bodily Injury (continued)

A. Income Replacement Indemnities

Category	Compensation Amount ¹	
	Maximum	Minimum
(c) For the delay actually caused in arriving on the job market	Annual amount of: • \$11,250.39 for secondary students • \$14,154.33 for post-secondary students minus what they make under (a) and (b)	
(d) Once studies are finished or stopped, if unable to work due to the accident	• \$215.76 per week for secondary students • \$271.45 for post-secondary students	Idem Idem
7. Persons age 65 or over	Indemnity based on the accident victim's situation at the time of the accident. Pension ¹ based on the same criteria, according to whether the person falls under category 1, 2, 3, 4 or 6	

B. Other Indemnities

Category	Compensation Amount ¹	
	Maximum	Minimum
1. Lump sum indemnities for permanent bodily injury or disfigurement	\$36,327.06	
2. Indemnities for the reimbursement of certain expenses incurred as a result of the accident (if they are not covered by another social security plan)	Reimbursement of expenses approved by La Régie upon presentation of appropriate supporting documents	
3. Rehabilitation indemnities	Payment for materials and services necessary for the accident victim's social and professional rehabilitation, in accordance with a rehabilitation program approved by La Régie	

II Fatal Injuries

A. Pension-Type Death Benefits

<u>Victims with Dependents³</u>	<u>Compensation Amount¹</u>
One dependent	55% of income replacement indemnity they would have been entitled to had they survived. Minimum: \$145.31 per week
Two dependents	65% of this indemnity Minimum: \$163.48 per week
Three dependents	70% Minimum: \$181.65 per week
Four dependents	75% Minimum: \$199.82 per week
Five dependents	80% Minimum: \$217.99 per week
Six dependents	85% Minimum: \$236.16 per week
Seven dependents	90% Minimum: \$254.33 per week
Persons with no spouse or other dependent who ensured the viability of family business	Minimum: \$145.31 per week for a maximum five-year period

B. Lump Sum Death Benefits

<u>Victims with Dependents³</u>	<u>Compensation Amount⁴</u>
Persons with no spouse or other dependent	\$7,432.26 to parents of accident victim or \$3,716.13 to the victim's estate
Funeral costs	\$2,477.42

³ For the purposes of the Automobile Insurance Act, the spouse is always considered the victim's dependent.

⁴ In the case of pension-type benefits, the pension is decreased by the amount of the surviving spouse's pension and orphan's pension payable under the Quebec Pension Plan or a similar plan outside Quebec.

APPENDIX 13

Excerpt from

Claude Fluet and Pierre Lefebvre

"L'Assurance automobile au Québec: Bilan d'une Réforme"

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Translated by
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CHAPTER 1

Introduction

It is now 7 years since automobile insurance reform was introduced in Quebec. To most observers, there is no doubt that the new protection, with respect to both bodily injury and property damage, is proving to be a marked improvement over the situation which existed prior to 1978. Nevertheless, no comprehensive evaluation is available regarding the results stemming from the measures introduced in 1978 and the changes contained in the Automobile Insurance Act. Of course, a number of sources such as the Activity Reports and the Statistical Reports from the Régie de l'assurance automobile du Québec (the Quebec Government Automobile Insurance Board), the Reports re. Automobile Insurance Rating in Quebec from the Inspector General of Financial Institutions or the Statistical Reports from the Insurance Bureau of Canada are likely useful in judging the new plan and determining to what extent it has achieved its aims. However, these reports are, first and foremost, factual and only present certain quantified results connected to the field of automobile insurance. They are not inspired by the type of explicit analysis whose purpose would be to identify and follow the evolution of the net social benefits of the 1978 reform, the effects of which will necessarily be spread over time. Moreover, the 1978 reform went beyond the bounds of bodily injury. It consisted of introducing a system composed of two "sub-systems".

The most important of these was the Régie de l'assurance automobile, set up to deal with prevention and bodily injury; the other was to concern itself with all measures regarding property damage (direct compensation, compulsory third party insurance, cancellation of subrogation, appraisal centres). It is clear, however, that these sub-systems are interdependent, the one acting upon the other.

A more in-depth and systematic analysis of the socio-economic impact of the 1978 reform can only improve the determinant information available regarding automobile insurance policy. The purpose of this study is to examine the reform and to clarify certain questions and proposals currently being discussed regarding automobile insurance. We have used a cost-efficiency assessment of automobile insurance from the beneficiary's point of view. In other words, we have tried to relate the level of protection granted and the cost of that protection. The study consists of three parts:

(i) an analysis of the development of the private market for automobile insurance with respect to property damage, in order to define the effects of the reform on both the automobile insurance industry and on the cost to the consumer of property damage insurance;

(ii) an evaluation of the achievements of the bodily injury compensation plan introduced in the 1978 reform, on the basis of the aims of that reform and our knowledge of the situation prior to the reform;

(iii) lastly, a global evaluation of the reform, describing the evolution of the overall cost of the insurance in relation to changes in the levels of protection.

These points, in this order, are enlarged upon in chapters 3, 4 and 5 of the study. Chapter 6 provides a brief conclusion. Lastly, a summary of the principal results may be found in chapter 2.

CHAPTER 2

Chapter Contents, Summary and Conclusion

The private market of the automobile insurance since 1978 (Chapter 3)

The Automobile Insurance Act, passed in 1977, assigned to a government board the administration of the new basic compensation plan for victims of bodily injury sustained in automobile accidents. As the compensation relative to bodily injury represented approximately 1/3 of all indemnities paid by the private Insurers prior to the reform, it was obviously anticipated that, after the Act took effect in March, 1978, it would mean a substantial reduction in sales for the private automobile insurance industry. This effect was to be somewhat mitigated by the fact that vehicle owners now had to insure themselves with private Insurers for third party liability for property damage. Prior to the reform, it was estimated that slightly less than 90% of vehicles were covered by a liability insurance contract. The 1977 Act also contained a number of additional provisions whose effect was to change automobile insurance practices and whose specific objective was to reduce the cost of settlement of automobile claims. This is notably the case where private Insurers were obliged to adopt an agreement of direct compensation and to establish accredited appraisal centres for the appraisal of vehicle damaged in accidents.

Chapter 3 analyzes the effects of the 1977 Act on Quebec's private automobile insurance sector. This is done from two points of view - the effects on the industry alone and from the perspective of the insurance consumer. Section two of this chapter lists the chief provisions of the Act regarding the private practice of automobile insurance. Section three assesses the level of adjustment of the industry to the plan's reform. Section four examines the effects of the reform from the perspective of the insurance consumer with respect to compensation for property damages. Lastly, section five provides a brief synopsis and some general conclusions.

Summary and Conclusion

The analysis submitted in this chapter leads to the following conclusions or main findings:

1) The Automobile Insurance Act has had no appreciable impact on the number of practising automobile Insurers in Quebec. There has been no change in the concentration level in this sector of activity - the market share of the five major groups of Insurers remains approximately 35%. There has not been any significant change either in the market share of Insurers having their Head office or main office in Quebec. Such share is, as in the early 1970s, slightly more than 50% of subscribed premiums.

2) Since 1978, almost all passenger vehicles - an average of more than 96% depending on the year - have been insured for third party liability in accordance with the requirements of the Act. This proportion was slightly lower than 90% prior to the reform. The proportion of vehicles with collision coverage has also risen (from 52% to 60%), as has the proportion of vehicles carrying comprehensive insurance (from 74% to 80%). This increase in the proportion of vehicles insured under various types of coverage has, to some extent, lessened the decrease in business in the private automobile insurance industry. The transfer of compensation for bodily injury to a public plan represented in itself an approximate loss of business of 31% (bodily injury made up almost half the costs and premiums of third party liability). All else being equal, the increase in the proportion of passenger vehicles insured under various types of coverage has reduced the loss of business to approximately 23% of what the Insurers would have collected had the reform not been implemented.

3) The years immediately following the reform (1978, 1979) were characterized by a slight rise in accident frequency, although this shouldn't really be seen as a simple cause and effect relationship, but rather as a result of a normal cycle in the insurance business. During this period, there was, however, a substantial increase in the frequency of claims made under third party liability coverage. This increase was totally

different from that observed with respect to collision coverage. The frequency of third party liability claims rose to 12% in 1979-81, compared to an average of 9.6% over the 1973-78 period. However, there was no significant change in the frequency of claims under collision insurance (9.6% in 1979-81, as compared to 9.9% for the earlier period). It appears that this asymmetrical increase in accident claims must be attributed to the new rules introduced in the Direct Compensation Agreement and some of its provisions, notably the "amicable reporting" provision. This development has also resulted in compensation of a larger number of small claims, as opposed to what was previously the case. It is still too soon to say whether this shift in claims notification from collision to liability coverage will be a permanent phenomenon or whether the Insurers and the Insured are simply going through an adjustment period (over the 1982-84 period, the frequency of liability claims fell back to its historical level).

4) Compensation for bodily injury is the principal reason for the increase, in real terms (i.e. aside from what could be expected due to inflation), of the cost of automobile insurance in Canada, excluding Quebec. For bodily injury, the average rated dollar cost per liability claim rose by 135% between 1978 and 1984, compared with an increase of 62% for property damage. This evolution is linked to the substantial increase, in real terms, of the settlements awarded by the courts under third party

liability proceedings. Conversely, in Quebec, the implementation of a plan to administer compensation for bodily injury resulted in control of the increase of costs and premiums (which characterized private automobile insurance), as compared with what was occurring elsewhere in Canada, even after the single adjustment (which was, of necessity, associated with this shift) had been eliminated. In other words, the Quebec government plan inherited that area of automobile insurance protection which experienced the most rapid cost increase elsewhere in Canada (in the provinces with private systems).

5) The years immediately following the reform (1979, '80, '81) were years of poor financial performance by the private automobile insurance industry in Quebec, as much at the level of underwriting losses as at the level of net industry profits - the combined result of a normal insurance cycle (these years being characterized by an increase in accident frequency) and the industry's adaptation to the loss of sales resulting from the reform. The cost of claims/underwritten premiums ratio went from 74.6% in 1973-78 to 98.2% in 1979-81, subsequently declining to 64.0% in 1982-84, giving an overall average of 81.1% for the 1979-84 period. The significant increase in this ratio during the sub-period 1979-81 is thus attributable to a "normal" increase in claims frequency and, in all likelihood as well, to the downward pressure on premium rates due to increased competition resulting from a temporary glut in the industry. The ratio increase for the overall

period subsequent to 1978 is also attributable, to a lesser extent, to the rise in interest rates which altered the industry's financing structure, i.e. the premiums/investment income ratio.

6) However, for the overall period 1978-84, there was no significant drop in the profitability of private automobile insurance in Quebec. The return on equity in the industry was thus essentially the same over the 6 or 7 years following the reform as over the 6 or 7 years preceding it, i.e. an after-tax return rate of approximately 15% for the sample firms studied. However, in the absence of a structural disturbance such as occurred in 1978 and assuming that the level of competition characteristic of the industry remained constant, one would have expected an increase in the industry's return rate, due to the increase in interest rates, together with a "loss" of underwriting profits. This is what occurred elsewhere in Canada in the general insurance industry; the before-tax return rates went from approximately 7% to 10% from one sub-period to the other, at the same time as the underwriting experience was declining. In this sense, it seems appropriate to speak of a relative deterioration in the profitability of automobile insurance in Quebec (which now appears to move closer to the norm for Canada). It is conceivable that this relative deterioration may be due to an increase in competition. Once again, it is too soon to judge whether this will be a permanent trend.

7) Total automobile insurance expenses may be expressed as the total of net claims paid to the Insured plus the operating costs of the Insurers (including claims settlement costs). In the middle term, the operating costs/total expenses ratio constitutes a yardstick of the system's efficiency or the "real" cost of insurance services. In the short term, as some costs do not vary proportionate to the indemnities actually paid, the ratio will depend on fluctuations in claims frequency. This ratio dropped slightly following the 1978 reform, from an average of 38% over the 1973-78 period to 34% over the 1979-84 period. This drop can be attributed only partially to the relative increase in claims frequency from 1979 to 1981. On the basis of a functional breakdown of operating costs into acquisition and marketing costs, underwriting and policy sales costs and, lastly, claims settlement costs, it appears that it is the decrease in the relative importance of the latter which made the greatest contribution to the drop in the operating costs/total expenses ratio (direct and indirect settlement costs which accounted for 38.7% of the operating costs in 1974 dropped to 33.0% in 1979-80 and to 28.1% in 1981-84). It was impossible to verify to what extent this was due to the elimination of compensation for bodily injury or to a greater efficiency in dealing with property damage (further to the introduction of damage appraisal centres and the Direct Compensation Agreement). It could be noted that the phenomenon occurred despite the fact that a relatively larger number of small claims were now being compensated for both third party liability as well as collision insurance (where the average deductible was significantly lower in real terms).

8) "Return to the Insured" is usually defined by the net indemnities/premiums ratio. This ratio is commonly used as an indication of the benefit received by the Insured in return for insurance premiums paid. This ratio went from 58% in 1973-78 to 67% in 1979-84 (i.e. 81% in 1979-80 and 60% in 1981-84). Similarly, the inverse ratio (i.e. premiums paid per dollar of net indemnity paid) measures the relative cost of the insurance to the Insured. This cost went from 1.74 in 1973-78 to 1.50 in 1979-84 (i.e. a decrease of 14.8%). This relative cost could be expressed as the product of total expenses/net indemnities ratio by premiums/total expenses ratio. These two ratios fluctuate in the short term according to more or less predictable variations in accident frequency. To the extent that these fluctuations can be disregarded over the entire period of 1979-84 and the average ratios for the period thus be considered as representative of a complete cycle, the following conclusions may be drawn. As we saw in point 7, the first ratio is an indicator of the insurance industry's operating efficiency - the decrease in this ratio (due solely to an apparent increase in the efficiency of claims settlement) in itself accounts for 47% of the decrease in the relative cost of insurance. The second ratio (premiums/total expenses) is dependent on the financing structure of the Insurers, i.e. the contribution of premiums in relation to investment income to the financing of their total expenses, and the industry's profit margins, or in other words on the amount of competition. The decrease in this second

ratio accounts for 53% of the decrease in the relative cost of insurance. Keeping in mind the points outlined in 5 and 6, two factors come into play in explaining the decrease in this ratio. Firstly, the significant rise in interest rates at the beginning of the second sub-period resulted in an increase of the relative contribution of investment income as a source of financing (despite the reduction in settlement time limits). Secondly, due to an increase in competition resulting from perhaps only a temporary glut in the industry, the profit margins normalized in relation to what may be observed elsewhere in Canada. A rough breakdown attributes 2/3 of the decrease in the second ratio to the normalization of profit margins and the remaining 1/3 to changes in the financing structure. Consequently, in total, the decrease in the relative cost of insurance is due 47% to increased efficiency in claims settlement, 35% to the normalization of profit margins, and 18% to changes in the insurance financing structure.

The Government Automobile Insurance Plan since 1978 (Chapter 4)

The Government Insurance Plan introduced in 1978 deals exclusively with compensation for bodily injury (as opposed to property damage) resulting from traffic accidents. The administration of this plan was entrusted to the Régie de l'assurance automobile du Québec, a corporation

under the meaning of the Civil Code, incorporated in 1977, with its first fiscal year commencing on March 1, 1978. Chapter 4 analyzes the public sector of automobile insurance in Quebec since the 1978 reform. As the amount of optional bodily injury insurance taken out through private Insurers subsequent to that time is, for all practical purposes, negligible, almost the entire field of bodily injury insurance will be covered here. As much as possible, this chapter has been laid out in the same manner as Chapter 3. Section 2 of Chapter 4 describes the aims and basic features of the plan. Section 3 provides the principal statistics necessary for analysis of the evolution with respect to indemnities paid, operating costs and financing. Section 4 analyzes the plan's performance from the Insured's perspective. Lastly, Section 5 summarizes the chapter and draws the chief conclusions from it.

Summary and Conclusion

The main conclusions to be drawn from this chapter are as follows:

- 1) The universal insurance plan introduced in 1978 and administered by the Régie de l'assurance automobile du Québec covers almost the entire field of bodily injury insurance in Quebec. Since 1978, this plan has received

approximately 93% of the insurance premiums relating to this protection and has paid out approximately 97% of the net indemnities. The residual portion, supplied by the private sector, provides funds for bodily injury insurance under the third party liability coverage for accidents occurring outside of Quebec and for the optional, supplementary insurance taken out by some individuals.

2) Taking into account all indemnity categories, over the last 7 years, the Régie has paid out a yearly average of 54,000 new indemnities to 28,200 dead (their beneficiaries) or injured victims of traffic accidents. Almost 40% of the indemnities are paid out as pensions, either as death benefits or income replacement indemnities. Close to 60% are lump sum payments or compensation paid for reimbursement of medical, paramedical, or other expenses. During the period under study, approximately 36% of injured, but surviving, victims received income replacement indemnities for actual or assumed loss of income. Fifty per cent of the victims held full-time employment; 50% were not, voluntarily or otherwise, on the job market (minors, students, people at home, invalids, etc.). In all cases, the beneficiaries of the deceased received an indemnity for funeral expenses, i.e. 100%; approximately 36% received death benefits as a pension and 66% a lump sum payment (the latter two categories being mutually exclusive). The income replacement indemnities represented, on average, approximately 62% of

the total value of indemnities paid (after deduction of related administrative expenses); death benefits made up 21% of this total and 17% related to other indemnities.

3) Separating the Régie's administrative expenses into those relating to the compensation plan and those relating to its other mandates is difficult. The net indemnities paid to victims of traffic accidents represent approximately 90% of the compensation plan's expenses stricto sensu, including related administrative expenses. These expenses represent approximately one-third of the Régie's total administrative costs; the remaining two-thirds apply to mandates other than insurance. Since the 1983-84 fiscal year, aside from promoting road safety as had been the case since the plan's introduction, these other mandates have included registration and issuing of licences, as well as administration of the Highway Safety Act. Aside from its registration and licence issuing activities (which are funded in large part by specific fees), the other mandates are financed by insurance contributions, either directly or through investment income from the stabilization reserve.

4) On an actuarial basis, the annual cost per fiscal year includes the actuarial cost of accident compensation for the fiscal year (including related administrative expenses) and the cost of the Régie's other mandates.

This cost is funded through insurance contributions, licensing fees, and investment income earned on both contributions and on the stabilization reserve. For the overall period 1979-84, indemnity costs generally tended to be over-estimated, resulting in frequent downward revision in actuarial liabilities and, consequently, the building up of a large stabilization reserve. This over-estimation was essentially due, especially in the plan's initial stages, to the reduction in the disability periods of victims compensated by the Régie, compared to the accumulated actuarial experience of the private Insurers over the 5 years prior to the reform. The mid-term reserve for the 1983-84 fiscal year thus represented 78% of the insurance contributions received during the course of that year; this is clearly higher than the equity/premiums ratio of approximately 50% that is usually seen in the private general insurance industry. During the later years of the period under study, this cost over-estimation permitted financing of a growing portion of the cost of each fiscal year from the stabilization reserve, resulting in operating losses at the end of the period (before extraordinary items). At the beginning of the period, the projected financing was: insurance contributions - 95%, investment income - 5%; at the end of the period, it broke down as follows: contributions - 77%, investment income - 13%, reduction of the stabilization reserve - 10%. The actual financing at the end of this period was, however, 82%, 13% and 5%

respectively for these three items. The reductions in the stabilization reserve were not, however, realized due to a downward revision in actuarial liabilities representing approximately 25% of the cost for the fiscal year.

5) A rough comparison between the current plan and the situation prior to the reform suggests that the proportion of traffic accident victims actually receiving compensation rose from approximately 41% to almost 50% - an increase of approximately 20% in the frequency of compensation. If analysis is limited solely to those who sustained serious injury, it may be concluded that almost all of these victims have been compensated. The time limits for settlement to compensated victims have been significantly reduced. While 65% had previously received no compensation 6 months after their accidents, this is only true of 4% of cases under the new plan. With adjustment of the compensation levels to correspond to the increase in the average earned income in Quebec, the indemnities per compensated victim rose approximately 14% with the reform. Taking into account the increase in the frequency of compensation, this translates as an indemnity increase of approximately 35% per accident victim. Lastly, the relative cost of insurance - total expenses (including related administrative costs) per dollar of net indemnity - has decreased significantly from approximately 1.63 to 1.13. The relative price of insurance decreased in more or less the same proportions.

6) Reduction in insurance administration costs is explained by the elimination of the concept of "fault" and by the regrouping of the various administrative activities within a single organization. This not only allows advantage to be taken of economies of scale, but also the elimination of some specific costs relating to competition, notably in the area of marketing. The regrouping into a single organization also facilitated certain related activities, such as the promotion of road safety and organization of efficient rehabilitation services.

A Global Evaluation of the Reform of 1978 (Chapter 5)

This chapter contains a comprehensive evaluation of the 1978 reform, taking into account both private insurance and the government plan, and deals as much with property damage as bodily injury. Section 2 describes the evolution of the structure of automobile insurance in Quebec, based on premiums, compensation and costs, as well as a public/private and bodily/property breakdown. To put things into perspective, the evolution of variables in constant dollars will also be described. Section 3 deals with the development of the common efficiency indicators, allowing a global evaluation of profits attributable to the reform to be covered in Section 4. Section 5 reviews a number of questions to do with insurance financing and

premium evolution while taking profits and taxation into consideration. Lastly, Section 6 compares the government plan in Quebec with the private system in force in Ontario and the government systems in the western provinces.

Summary and Conclusion

Confining ourselves to basics, the implications of the 1978 reform of the automobile insurance plan in Quebec, as it pertains to both bodily injury and property damage insurance, may be summarized as follows:

1) The structure of the automobile insurance system has been drastically altered. Based on actuarial evaluations made one year after the end of each accident year, approximately 97% of the net indemnities paid as compensation for bodily injury are now paid by the public plan introduced in 1978. Moreover, based on these same evaluations, bodily injury indemnities now account for approximately 39% of the total net automobile insurance indemnities, compared to 35% prior to the reform.

2) The average level of bodily insurance indemnity per compensated victim rose substantially in constant dollars (by almost 35%), as did the frequency of compensation of traffic accident victims (by 18%). This same

phenomenon is noted to a lesser degree with respect to property damage insurance, due to an increase in the number of insured vehicles and a broadening of vehicular insurance coverage (reduction in the real level of the deductible and a larger number of optional insurance coverages).

3) The anticipated efficiency gain related to the introduction of a public plan for bodily injury insurance and the rule changes with respect to private insurance for property damage (Direct Compensation Agreement, etc.) had actually been realized. From the sub-period 1973-77 to the sub-period 1978-84, the total expenses/net indemnities ratio declined 4% with respect to property damage and 36% with respect to bodily injury insurance - a total reduction of 15%.

4) The average premiums or contributions of blanket coverage per vehicle actually insured for third party liability in Quebec have risen, in real terms, between 1973-77 and 1978-84. The average premium rose by 1.5% for bodily injury insurance and by 9.6% for property damage insurance - an average total increase of 6.7% per insured vehicle. The premium increase factors for both types of coverage are: the increase in the real level of indemnities per victim or compensated claim, and the increase in the frequency of compensation. There is also a slight increase in the frequency

of property damage accidents. These increase factors are offset to a large extent, however, by the increase in return to the Insured (efficiency gain and changes in the method of financing) and by a broadening of the premium collection base (increase in the number of vehicles contributing to insurance financing in relation to the overall number of vehicles on the road). It may be observed that part of the increase in return to the Insured for bodily injury results from the elimination of certain taxes or levies and is thus borne by the taxpayers in general.

5) A rough comparison with the features of the private insurance system in force in Ontario suggests that the insurance structure in Ontario puts greater emphasis on bodily injury. For the 1978-84 period, the gross bodily injury indemnities/total gross indemnities ratio was 43% in Ontario, compared to a net indemnities ratio of 39% in Quebec (for 1982-84, the ratio in Ontario rose to 50%). This appears to be accounted for by the extremely high level of average indemnity per bodily injury claim (for third party liability) in Ontario following judgments awarded by the courts over the past few years. However, it must be kept in mind that we are dealing here with gross indemnities which include the Insurers' settlement expenses and, particularly, the litigation expenses borne by the Insured. The return to the Insured is much higher in Quebec than in Ontario, due solely, however,

to the government bodily injury insurance plan. The return to the Insured in Quebec is roughly the same (although slightly better) as that seen in the government systems in Canada's western provinces.

Conclusion (Chapter 6)

With respect to compensation for both property damage and bodily injury (in a more marked fashion, obviously, in the latter instance), evaluation of the reform appears quite positive: overall protection increased; an appreciable efficiency gain resulted in reduction of the relative costs of insurance; the more qualitative aspects of the compensation procedure also underwent definite improvement. The reform of 1978 had taken a stand on certain basic issues which were, and still are, relatively controversial in the public mind. Three basic choices may be identified in this respect: elimination of the concept of "fault" and the right to recourse; lump sum compensation on the basis of predetermined scales for non-monetary losses; administration of the plan by a public board. These three basic choices appear, in retrospect, to be justified.

APPENDIX 14

THE AMERICAN EXPERIENCE WITH NO-FAULT AUTOMOBILE INSURANCE WITH SPECIAL REFERENCE TO THE MICHIGAN SYSTEM

In the United States, the Department of Transportation (DOT) recently completed a Follow-Up Report on No-Fault Auto Insurance Experiences entitled "Compensatory Auto Accident Victims" (May 1985). This is an extremely useful study which provides a great deal of insight into the performance of the variety of no-fault systems that now exist in the United States. More importantly, it sets out the key criteria which should justify a fundamental shift to no-fault insurance in Ontario at least in respect of automobile insurance, and perhaps also in respect of all accidental injury.

The following discussion will set out the performance criteria and the conclusions drawn from the DOT study. Then, the Michigan system of no-fault automobile insurance combined with a very high verbal threshold will be examined in greater detail.

The DOT study examined two types of no-fault auto insurance: no-lawsuit no-fault, and add-on no-fault. These were defined as follows:

No-lawsuit is the form of no-fault under which a motor vehicle accident victim can always receive no-fault benefits but cannot always bring a lawsuit against the person whose fault caused the accident and injury, on the ground that lawsuits are unnecessary in some cases, where victims have a right to no-fault benefits. The term "no-lawsuit" is not totally accurate because each of the States that today restricts lawsuits by recipients of no-fault benefits does allow some such lawsuits under certain circumstances. The term is nevertheless appropriate because it emphasizes the primary distinguishing feature of this category: lawsuit restriction in exchange for assured no-fault benefits.

Add-on is the particular form of no-fault that does not restrict a victim's right to bring a lawsuit against any other person believed to be at fault, while at the same time providing assured no-fault benefits to that victim. Under add-on auto insurance, lawsuits and no-fault benefits are both always allowed. In the States that have this kind of auto insurance, the right to recover no-fault benefits is always a supplement to, rather than a substitute for, the traditional right to sue the wrongdoer. (pp.1-2)

In considering the most appropriate no-fault scheme, the central issue is the question of balance. This "refers generally to the trade-off between the savings from restrictions on lawsuits and the added costs of providing new no-fault benefits. More specifically, to have 'balance' in a no-lawsuit system, the system must have effective restrictions on lawsuits such that the savings generated by limiting lawsuits and thus constraining third-party payments must be lower than the average amount of the third-party damages will 'pay for' the cost of first-party benefits. To have balance in an 'add-on' system, where there are no restrictions on lawsuits, the average amount of the third-party payments in traditional States by such an amount that the 'savings' will equal the cost of first-party no-fault payments" (p. 3).

The following general conclusions were drawn by the DOT study based on over 12 years of experience in 24 jurisdictions, and are worth reproducing in detail:

1. Significantly more motor vehicle accident victims receive auto insurance compensation in no-fault states than in other states. Almost twice as many victims per hundred insured cars receive PIP benefits in no-fault states as receive BI liability payments in traditional states.
2. In general, accident victims in no-fault states have access to a greater amount from auto insurance than victims in traditional states.
3. Although no-fault states, on average, have higher total insurance premiums than traditional states, this seems to be due to the inclusion in the average of no-fault states with laws that are out of balance. From 1976 to 1983, the average auto insurance premium in the average traditional state rose 50%. During the same period, the average auto insurance premium rose (a) 54% in the average no-fault state with a law that is in balance, and (b) 126% in the average no-fault state with a law that is not in balance.
4. "Balance" in no-fault systems seems to be closely linked to the presence of an exclusively verbal or a high medical expense dollar threshold. In fact, the appropriateness of the threshold is likely to be the principal factor in determining whether a system is in balance. (Note that all of the states which permit recovery of third-party benefits only upon satisfaction of a verbal threshold are in balance. Michigan is the outstanding example.)
5. Compensation payments under no-fault insurance are made far more swiftly than under traditional automobile insurance.
6. No-fault insurance systems pay a greater percentage of premium income to injured claimants than do traditional liability. One of the highest rates, 55.1 cents of each personal injury premium dollar, was reached by the state of Michigan, the state which provides the greatest amount of no-fault benefits to accident victims and which puts the strongest restrictions on lawsuits and third-party benefit recoveries.
7. State auto insurance laws which provide high no-fault benefits would appear to better facilitate the rehabilitation of seriously injured motor vehicle accident victims than traditional laws, although the lack of good data on rehabilitation experience under traditional laws precludes a good quantitative estimate of the difference.
8. No-fault has led to reductions in the number of lawsuits and, thus, to significant savings in court and other public legal costs paid by the taxpayer. According to Chief Justice Warren Burger, each jury trial tort case costs the taxpayer approximately \$8,300 in court and other public costs, while the precise level of savings entities is substantial.

9. Typical auto insurance benefits in both no-fault and traditional states fall short of the needs of catastrophically injured victims. Only the no-fault laws in Michigan and New Jersey, which provide for unlimited medical benefits, meet the medical needs of all victims of catastrophic injury.
10. The percentage by which the cost of payments to accident victims in no-fault states exceeds the cost of such payments in traditional auto insurance states has increased from 1976 to 1983. This suggests that it is necessary to consider new ways to reduce costs, such as repealing the collateral source rule and/or putting a ceiling on pain and suffering damages that an accident victim can receive if that victim was also eligible to receive no-fault benefits.
11. No-fault automobile insurance laws do not lead to more accidents.

The foregoing points and the detailed back-up statistical analysis clearly reveal the advantages of a well-balanced no-fault system, preferably with a verbal threshold to limit lawsuits, over the traditional auto insurance system. It is important to note, as well, certain key features of the no-fault no-lawsuit system before turning to a specific analysis of the Michigan example. These are as follows:

- o Most no-fault no-lawsuit states have concluded that the no-fault insurance should be compulsory rather than voluntary, and that this should be coupled with compulsory personal injury liability insurance. (Note that Ontario has had compulsory automobile insurance since 1979.)
- o Some no-fault no-lawsuit states also require the purchase of uninsured motorists' insurance and/or require it to be offered or issued to all policyholders. This bears no direct relationship to no-fault insurance. Rather, the requirements reflect a contest between those who supported a total change to no-fault compensation and those who supported only an improvement or cure to the imperfections of the traditional tort-based liability insurance system. (Note that Ontario insurers provide such coverage.)
- o Only Michigan has opted for no-fault property insurance in addition to no-fault personal injury insurance. However, millions of Americans purchase automobile collision insurance and automobile comprehensive insurance as traditional forms of first-party property insurance.
- o Most no-fault states give the policyholder the option of purchasing PIP coverage with a deductible. The effect of the deductible is to enable the motorist with health insurance or other assets to do without automobile insurance benefits to the extent of that deductible, and thereby pay a low auto premium.
- o No jurisdiction provides no-fault benefits for pain and suffering damages or non-pecuniary losses.

Having now set out the key features of any no-fault, no-lawsuit automobile insurance plan, it is useful now to turn to the specific Michigan experience. The reason for this focus is that it appears that the Michigan system is superior to all the other American examples in terms of the five criteria by which the effectiveness of the system should be judged: (i) its cost in terms of average premiums; (ii) its benefits to injured automobile accident victims; (iii) the speed with which it pays those benefits; (iv) the percentage of the money collected as premiums which it pays to accident victims as benefits; and (v) the extent to which the system is in balance or not in balance.

To begin with, the Michigan system is succinctly summarized as follows (p.34):

MICHIGAN

Mich. Comp. Laws Ann. §500.3101, effective 10/01/73

MAXIMUM PIP BENEFITS

Medical and rehabilitation expenses	Unlimited
Wage loss (85% for 3 years @ \$1,475 per month)	\$53,100
Replacement services loss (3 years @ \$20 per day)	21,900
Survivors' loss (\$1,475 per month for 3 years)	53,100
Funeral expenses	<u>1,000</u>
Total per victim:	Unlimited

THRESHOLD FOR LAWSUIT IN TORT

Monetary: None.

Verbal: Death, serious impairment of a bodily function, or permanent serious disfigurement.

OTHER IMPORTANT PIP (NO-FAULT) PROVISIONS

- Penalty for late payment of PIP benefits.
- No excess PIP insurance need be offered by insurers.
- Deductible of \$300 per accident required to be offered.
- Deductible and exclusion "reasonably related to other health and accident coverage on the insured" required to be offered.
- PIP benefits are primary, except that policyholder can designate his or her health insurer as the primary provider of medical benefits resulting from an auto accident.
- Coordination of PIP with health insurance required.

GENERAL INSURANCE PROVISIONS

- PIP compulsory, except as to motorcycles and mopeds.
- BI liability compulsory with \$20,000/\$40,000 limits.
- Uninsured motorists: no provision in law.
- Underinsured motorists not required to be offered coverage.

1983 PERFORMANCE DATA

	PIP	BI	
• Average premium:	\$ 63	\$ 55	
• Percentage of Total PI Premium:	53.49%		46.6%
• Paid Claims, Number:	39,850	9,507	
• Paid Claims, Total Amount:	\$168.5 million	\$117.98 million	
• Paid Claims, Average Amount:	\$4,230	\$12,410	
• Paid Claim Frequency:	1.23	0.29	
• Payout/Pay in Ratio:	55.1%		
• Average Total Limits Premium:	\$153.72		

Overall Change in Injury Insurance Costs as a Result of No-Fault: -17%.

A few observations on several aspects of the Michigan plan are useful. First, the Michigan no-fault law comes closest to a complete no-lawsuit, no-fault law. The law eliminates the right to tort action for losses resulting from bodily injury in automobile accidents, except in cases where economic losses exceed the benefits provided by no-fault insurance, or when non-economic losses exceed a pre-defined threshold. The threshold above which tort action is still permitted to recover non-economic losses is defined as follows:

A person remains subject to tort liability for non-economic loss caused by his ownership, maintenance or use of a motor vehicle only if the injured person has suffered death, serious impairment of bodily function, or permanent, serious disfigurement.

In other words, the threshold requires significant bodily impairment before permitting the right to sue. Permanent disability and scarring qualify, but lesser injuries (such as minor whiplash or hairline fractures where there is complete recovery at an early date) do not. In practice, however, some types of minor injuries have been compensated, even if they were not permanent, because the words "serious impairment of bodily function" have been liberally interpreted.

Tort action is also permitted if an injury was caused intentionally or if economic losses exceed the limitations of the benefits paid under no-fault.

Despite the substantial foreclosure of tort actions, however, it is interesting to note that State Farm Mutual Insurance Company has estimated that the average premium cost in 1983 for bodily injury liability (BI) coverage was \$55.00 - almost the same as its average cost for personal injury protection (PIP) coverage of \$63.00. Thus if all lawsuits were prohibited in Michigan (as in Quebec today), the average motorist would theoretically save \$55 on the cost of his or her car insurance - a reduction of almost 50% of the personal injury premium, although the actual savings would be less since insurers would increase the current PIP premium.

As the DOT study notes, as a result of the high verbal threshold, Michigan definitely experienced a significant decline in the number of automobile negligence cases filed in its circuit courts in the years after 1973 (the year no-fault went into effect).

According to a report prepared by the Michigan Insurance Bureau in 1978, the number of lawsuits remained relatively constant in 1974 and 1975, probably because the statute of limitations had not expired on pre-existing claims, but from July 1975 until June 1977 the number of lawsuits filed declined by approximately 31.3%. The Michigan Insurance Bureau also measured lawsuit potential indirectly by calculating the amount of the liability and residual liability claims paid by the six largest insurers in Michigan before and after no-fault became effective. The amount of money paid on liability claims by these insurers in the first year after accidents declined from about \$20 million annually in each of the three years before no-fault took effect to about \$1.5 to \$2 million annually in each of the three years after no-fault. For accidents occurring the year before no-fault became effective in Michigan, paid liability claims totalled \$46.1 million over the period extending from the time of the accident over the next 39 months; accidents occurring the year no-fault became effective resulted in paid liability claims of \$14.2 million over the same period. (p. 114)

A second important observation is that Michigan's no-fault system provides for unlimited medical benefits including substantial vocational rehabilitation benefits. And, in a recent ruling by the Attorney General in 1983, it was held that the Michigan law includes "all reasonable charges for reasonably necessary products and services to restore an injured person to a condition of physical health, as well as useful and constructive activity within the limits of his or her physical disability through vocational or occupational retraining, if necessary and reasonable".

The Insurance Bureau of Michigan made the following observations with respect to the value of rehabilitation in its 1978 review of no-fault auto insurance (p. 110):

Recent estimates have shown that for every dollar spent on rehabilitation, \$9 are returned through increased productivity, and that for every rehabilitated spinal cord injury, \$60,000 in future medical and nursing home costs are saved. However, a successful rehabilitation is generally possible only if an individual gets appropriate treatment as soon after the accident as possible. Placing a ceiling on PIP payments will serve to introduce uncertainty for the injured individual on whether or not he or she can afford rehabilitation treatments. This uncertainty inevitably causes delay and markedly reduces the possibility of successful rehabilitation.

And in 1982, a report by the All-Industry Research Advisory Council confirmed the Michigan estimates and the 1980 AIRAC findings as to the cost-benefit efficacy of rehabilitation in auto accident injury cases. "This study provides continuing evidence that physical rehabilitation procedures improve the functional independence of severely injured persons."¹

¹ AIRAC, Insurer Study of PIP Serious Injury Claims: Second Follow-Up (1982) (p.26).

One particular objection to unlimited rehabilitation and medical benefits raised by insurers is that it imposes an excessive and unfair burden on small insurance companies that happen to have insured a person who suffers a catastrophic injury. To overcome this problem, a special statute was passed that created an unincorporated, nonprofit association to be known as the Catastrophic Claims Association. The DOT Study described the association as follows (p. 126):

The Catastrophic Claims Association of Michigan is directed to indemnify Michigan's auto insurers, all of which are required to be members of the Association, for all losses under PIP claims in which the total loss is expected to exceed \$250,000 and to "calculate and charge to members of the association a total premium sufficient to cover the expected losses and expenses of the association" according to a statutory formula.

According to the November 1983 report of the Chairman of the Board of the Michigan Catastrophic Claims Association, the Board has approved a \$5.91 assessment per insured car to pay for the cost of indemnifying all companies for all medical expenses paid over \$250,000 per victim during the period from January 1 to December 31, 1984. Footnote 1 to the report indicates that the per-car assessment for all but the first year of the Association has been about the same, despite inflation in medical costs and despite increases in Michigan automobile insurance premiums. The smallness of the rate (\$6 per policy) and the lack of change in the rate of assessment over time suggest that paying unlimited medical and rehabilitation expenses via a catastrophic injury fund may be practicable.

From July 1, 1978, until June 30, 1983, 933 catastrophic claims cases were reported to the Michigan Catastrophic Claims Association (MCCA). Of this total, 550 (58.9%) involved brain injuries, 134 (14.4%) involved quadriplegia, and 129 (13.8%) involved paraplegia. Of the 933 victims, 662 (70.9%) were male. At the time of the accident, 406 of the victims (43.5%) were driving an automobile, 169 (18.1%) were pedestrians, and 64 (6.9%) were on a motorcycle that collided with an automobile.

After commenting on the AIRAC study of a group of catastrophically injured auto accident victims, the DOT Study has concluded that in the absence of high benefits, no-fault automobile insurance, it seems highly unlikely that there would have been sufficient resources available to treat these catastrophically injured victims and to provide for them the rehabilitation programs necessary to produce any significant improvement in their condition. The traditional system does not provide compensation for victims beyond the limits of liability insurance policy of an involved driver, and the normal liability policy is totally inadequate to pay the high costs of the care which the most severely injured typically require. Therefore, most of the cost of care for most of the catastrophically injured may have to be borne by the taxpayer, in the form of public assistance.

Two other objections of insurers to unlimited medical and rehabilitation benefits should be noted. These relate to the difficulty in assessing the potential exposure, and the overutilization of medical benefits by some physicians and other health-care providers. In this connection, State Farm has suggested the creation of medical peer review groups to which insurers could submit

questionable medical bills. Another possibility would be mandatory arbitration of disputed medical bills.

A third observation about the Michigan system pertains to no-fault property damage insurance. As noted above, Michigan alone prohibits lawsuits based on fault for automobile property damage in return for eligibility for first-party (no-fault) insurance. The law, however, is complex. It makes each Michigan motorist immune from being sued for property damage in excess of \$400 but it does not require the motorist to buy no-fault property damage insurance. The motorist can sue for vehicle damage up to \$400 where the amount is not payable by insurance, and can elect one of the following five options:

1. The motorist may choose to buy no collision insurance at all. Under this option the motorist in effect foregoes the ability to recover any compensation for property damages losses above \$400.
2. The motorist may choose to buy "limited collision" insurance with a deductible, which means that the motorist collects nothing if at fault, and the cost of vehicle repairs less the deductible if not at fault.
3. The motorist may choose to buy "limited collision" insurance without a deductible, which means that the motorist collects nothing if at fault, and the full cost of repairs if not at fault.
4. The motorist may choose to buy "regular collision" insurance, which means that the motorist collects the cost of repairing his or her own car, less a deductible, regardless of fault.
5. The motorist may choose to buy "broadened collision" insurance, which means that the full cost of repairs if not at fault, and the full costs of repairs less a deductible if at fault. (p. 135)

In recent years, the Michigan Insurance Bureau has had to put a great deal of effort into helping motorists to understand the law. And it now appears that, as of 1984, the number of complaints about the system has declined significantly.

One final observation: The Michigan no-fault no-lawsuit law, like all state laws limiting the victim's right to sue in return for no-fault benefits, has been upheld as constitutional. All courts have held that laws which deprive auto accident victims of a right to sue persons allegedly at fault are constitutional, provided they also guarantee that the victims receive benefits for at least some of their economic losses. It is equally constitutional to deprive the victim of the possibility of receiving both "pain and suffering" and economic loss damages if that victim is guaranteed the recovery of economic loss damages. The Supreme Court of Michigan has specifically held that no-fault insurance is constitutional because it "bears a reasonable relationship to a permissible legislative objective" and has a "rational basis". (Shavers v. Kelly, 267 N.W. 2d 72(1978).)

It would be appropriate to conclude this description of the Michigan system with the following comments of Michael LaMonica, the actuary with Allstate Insurance Company in Northbrook, Illinois. In a special submission to the Task Force, he summarizes why the Michigan system, as opposed to those in

force in other American states, is a very cost-effective way to increase the return of the premium dollar to victims of personal injury:

Of those states with restrictions on bringing suit, Michigan has the strongest threshold, commonly referred to as a "verbal threshold". Non-economic losses are recoverable only if injury results in death, serious impairment of bodily function, or permanent serious disfigurement; economic loss recovery is prohibited to the extent of first-party benefits received. This latter restriction is quite strong since Michigan has a very high level of first-party benefits. Medical benefits are unlimited and benefits are provided for 85% of wages lost up to \$2,434 per month for three years.

The cost savings on bodily injury liability in Michigan from the verbal threshold is about 50% as compared to pure tort. This savings has stayed relatively consistent since the inception of the law. New York and Florida also have verbal thresholds with savings of about 40%. This lower amount is due to the thresholds being somewhat weaker and to lower first-party benefits in these states. The cost savings in states with dollar thresholds (i.e., dollars of medical expense that must be incurred) show lower levels of savings, and in addition these savings have become less over time. This decrease in savings is due to the "target" created by the dollar threshold as well as inflationary erosion. Examples include New Jersey, where the initial savings on the \$200 threshold was about 25% but has since deteriorated to about 15%; and Pennsylvania, where initial savings of 25% for a \$750 threshold was down to less than 20% before its repeal in 1984. Other dollar threshold systems demonstrate savings of only 15% to 30%.

In summary, then, a verbal threshold similar to that in Michigan provides the largest savings on bodily injury costs. Dollar thresholds have shown a smaller degree of savings and the savings have deteriorated over time.

The increases in Michigan bodily injury premiums since no-fault have overall been comparable to bodily injury premium increases in tort states. Again, though, Michigan bodily injury premiums are about 50% less than what they would be in a pure tort system.

Another cost-saving feature of the Michigan law is the use of coordination of benefits: reduced first-party premiums are afforded where it can be demonstrated that the insured has other coverage, such as group health benefits, which are designated to be primary to the auto coverage. A large proportion of insureds utilize these options, saving 25% of first-party benefit premiums.

APPENDIX 15

THE NEW ZEALAND UNIVERSAL ACCIDENT COMPENSATION SYSTEM

Many observers have noted that, in principle and in theory, it does not make sense to distinguish between victims of automobile accidents and victims of other types of accidents. Thus if, with a view to furthering the public interest in an equitable personal injury compensation system, we shift to a no-fault basis for the compensation of automobile-related injuries, it might seem only logical and equitable to go further and implement a no-fault scheme for all accidental injury.

New Zealand alone has been the pioneer in recognizing the foregoing logic with the implementation of its accident compensation scheme in 1974. A brief description and assessment of the New Zealand model would be valuable.¹

The central concept in the accident compensation scheme is "personal injury or death by accident". This concept acts as a procedural bar to any common law action for damages and as an eligibility criterion for the payment of benefits under the Accident Compensation Act 1982. The common law action for damages for personal injury and the reception of statutory benefits are mutually exclusive concepts.

For those suffering injury or death by accident the coverage is comprehensive. With minimal exceptions it is of no concern where, how, when or why the personal injury or death by accident occurred. The victims of road accidents, work accidents, boating accidents, school accidents, hospital accidents - indeed accidents of any kind - are covered twenty-four hours a day. The only exceptions are those whose injuries are self-inflicted and those who have been injured as a result of criminal activities for which they have been convicted and imprisoned.

The centrepiece of the accident compensation scheme is income replacement known as earnings related compensation (ERC). As a general principle ERC is available to all earners, both employees and the self-employed, who are able to show that their injuries prevented them from earning to pre-accident levels. During the first week the employer pays 80% of income loss. After the first week the Accident Compensation Corporation pays 80% of lost earning capacity to all earners. ERC is subject to an upper maximum which includes 97% of New Zealand incomes. Provision is made for a permanent pension for the permanently disabled. The buying power of ERC is maintained with reference to increases in the New Zealand weekly average wage. Benefits are also paid to cover medical or dental costs not covered by the social security system.

¹ Much of the following is drawn from the paper prepared for the Task Force on Insurance by Philip Osborne entitled "A Critical Evaluation of Liability Insurance, Litigation and Personal Injury Compensation: The Lessons and Choices for Ontario".

The Act also covers the cost of future care, expenses directly resulting from the injury, loss of service of a domestic and household nature, and the cost of rehabilitation aids and training. Finally, the accident compensation scheme continues to award moderate lump sums for non-pecuniary loss. A lump sum not exceeding \$17,000 is payable for permanent loss or impairment of bodily function arising from the injury. The award is made on the basis of a schedule of physical impairment. In addition, a maximum sum of \$10,000 may be awarded for loss of amenities or capacity for enjoying life, and pain and suffering. Assessment is subjective and the loss must be of a sufficient degree to justify a payment. The assessment of the lump sum awards is made as soon as the medical condition has stabilized and no later than two years from the date of the accident. Clearly those lump sums play a subsidiary role and the crux of the scheme is compensation for pecuniary loss: both loss of income and the cost of future personal care.

In the case of a fatal accident, both ERC and moderate lump sums are payable to dependents. A totally dependent spouse receives ERC in the amount of three-fifths of the total that would have been payable to the deceased if he had survived with total loss of earning capacity. A partially dependent spouse is paid a proportionately reduced benefit. Payments continue so long as the condition of dependency lasts or until age 65. Dependent children are paid one-fifth of the amount that would have been payable to the deceased if he had survived with total loss of earning capacity. The total amount of ERC cannot exceed the maximum payable to the deceased if he had survived. Lump sums are payable in the amount of \$4,000 to a totally dependent spouse and \$2,000 to each dependent child. Reasonable funeral expenses are also covered.

There is a four-tiered system of review and appeal which includes an informal re-examination by the Accident Compensation Corporation, a formal hearing by a Review Officer of the Corporation, a further appeal to the independent Accident Compensation Appeal Authority and final appeal to the courts.

The Corporation is also charged under the Act to play an important role in rehabilitation and accident prevention and safety.

With respect to the financing of the scheme, it is funded predominantly by levies on employees, the self-employed and the owners of motor vehicles. The scheme for the first ten years was financed on a fully funded basis and during that time levies on the self-employed and employers were approximately 1% of leviable income and 15% of leviable payroll respectively and the annual levy on the owners of private automobiles was \$14 to \$20. In 1984 the basis of funding was changed to a modified pay-as-you-go system. Levy rates are set to provide sufficient reserves for the payment of approximately five years of entitlements. In 1985 to 1986 levy rates for employers dropped to 0.71% of leviable payroll. For the self-employed it continues to be 1.00% of leviable income. Levies on the owners of private automobiles rose to \$21.55.

Overall, one can conclude that the money flowing through the workers' compensation system and the automobile fault/insurance system was sufficient to finance the no-fault scheme and that the scheme is almost certainly cheaper than a continuation of the old system. It was estimated in 1982 that the accident compensation scheme resulted in annual savings of over \$100 for the

owners of private motor vehicles. Similar results have been predicted in Australia and the United Kingdom. It has been claimed that a similar scheme in Australia would save the country \$1 million per day¹ and the Pearson Commission found that a move to no-fault would result in an annual saving of 84 million pounds.²

The lessons to be learned from the New Zealand experience, both positive and negative, have been succinctly analyzed by Professor Osborne. They are as follows:

(a) Comprehensive Entitlement

There is a significant advantage in a scheme which provides comprehensive entitlement for all accident victims in society. Neither eligibility for compensation nor the level of benefits depend upon the class of person, the category of accident or the manner in which the accident occurred. Public uncertainty and confusion are reduced substantially when all accident victims are treated alike.

(b) Administrative Efficiency

The accident compensation scheme in New Zealand is administered by one institution - the Accident Compensation Corporation. This avoids the waste and confusion engendered by the current Ontario system where a disparate array of accident compensation vehicles all have their separate administrative structures. It also avoids the inordinate amount of time spent defining the parameters of each plan and resolving consequent questions of eligibility, set off and subrogation rights among them.

(c) Speedy Claims Processing

The scheme adequately addresses the major concern of speedy, predictable and certain income replacement. Payments to injured persons commence after an average delay of only ten days.³

(d) Low Administrative Costs

Compared to the fault/insurance system the administrative cost of the no-fault scheme is minimal. In New Zealand the percentage of administrative costs to total income in the year ending March 1985 was 8.4%, compared with 7% and 8.5% in the preceding two years. This should come as no surprise since Workers' Compensation, Unemployment Insurance and Canada Pension Plan in Canada operate on an administrative cost of less than 10% of total benefits. In 1984 the Accident Compensation Corporation employed 682 employees to process 159,106 claims and to carry out the Corporation's rehabilitation and accident prevention functions.⁴

¹ Woodhouse, "A Critique of the Fault System" in The Future of Personal Injury Compensation, a Symposium held at the Faculty of Law, University of Calgary, 1978, p.8.

² Atiyah, "What Now?" in Allen, Bourne and Holyoak, eds. Accident Compensation after Pearson, 1979, p.242.

³ Fahy, "The New Zealand Accident Compensation System", a paper presented at the Conference on Workers Compensation in Adelaide South Australia, May/June 1984, p.7.

⁴ Statistics drawn from Reports of the Accident Compensation Corporation.

(e) Eligibility Criteria

There is much greater certainty and predictability in respect of eligibility. In the year ending March 31, 1984, only 0.65% of all claims were rejected by the Corporation and in the following year the figure was 0.79%. Thus the general concept of "accident" appears to be well understood by the public and creates little practical difficulty.¹

(f) Reduction in Litigation

The no-fault system has proved to be a relatively non-litigious compensation system. In 1984 the Corporation handled 159,106 claims. There were 5,896 applications for a Review Hearing, of which 3,505 went to a full hearing. Thus only 3.7% of claims went to a hearing (1.7% in 1983). There were 294 appeals lodged with the Accident Compensation Appeal Authority. This figure is 0.18% of claims handled during the year.²

(g) Deterrence

New Zealand provides no demonstrable evidence on the deterrent function of tort law either way. Since accidents are no longer analyzed on the basis of fault there are no statistics on whether there has been an increase in negligent conduct. Claims have increased steadily year by year but they have been mainly in the area of sporting accidents and home accidents, where the tort would have less impact. In the area of work accidents, where one might have expected evidence of the loss of the deterrent impact of tort law, claims fell from 46,900 in 1980 to 44,269 in 1982. Claims may also have risen as a result of greater public awareness of the scheme and because society is getting more dangerous but not necessarily more negligent.

There has been some concern about an increase in defective products. However, New Zealand's product safety regulations are not as stringent as those in Canada and steps are being taken in New Zealand to tighten safety regulations in regard to products.

Overall, it seems fair to conclude that the absence of the fault/insurance mechanism did not have any fundamental impact on the extent of careless conduct in New Zealand. (See also Craig Brown article.)

(h) Lump Sum

It was probably a mistake to retain lump sum payments for loss of enjoyment of life, and pain and suffering. The assessment of these claims is subjective, individualized and meagre (maximum of \$10,000). It is productive of many hearings and appeals, a significant proportion of which involve legal representation. It causes dissatisfaction in respect of the low level of benefits. It would clearly have been better to incorporate the \$10,000 into the \$17,000 maximum for the scheduled payment for loss of bodily function.

(i) Administrative Style

There is little doubt that the Accident Compensation Corporation processes the great bulk of clear-cut accident claims in a speedy, simple and straightforward manner. However, there is reason for concern in respect of the handling of claims that are less clear-cut - the line-call cases. Margaret Vennell has commented:¹

In simple cases compensation payments are made comparatively rapidly but once the facts of a claim involve any difficult questions the establishment of the right to compensation becomes difficult and protracted. ... The Woodhouse Commission envisaged a speedy inquisitorial process, but in complex cases the adversary process of the common law has been replaced by an adversary process between the Accident Compensation Corporation and the victim.

The reasons for this rigid, legalistic and strict administrative style are not clear. Initially there may have been an understandable uncertainty and apprehension of the plateau cost and financial viability of such an untried scheme. This initial caution may have become institutionally entrenched. There has also been government pressure to contain the cost of the scheme. Much of the responsibility must lie with the senior administrators of the scheme, who appear to have regarded cost-cutting as a priority beyond all others. Some responsibility must lie with the legislation, which entrusted to the Corporation a high degree of discretion in decision-making. Discretion can be exercised conservatively just as easily as liberally. Some criticism must rest with the personnel in the Corporation, many of whom carried with them attitudes developed in the insurance industry whence they came. Finally, there are those who will claim that a narrow legalistic bureaucratic approach is inevitable in a governmental institution. Whatever the reasons, it is certainly one of the less attractive features of the scheme.

(j) Rehabilitation and Accident Prevention

The adoption of a universal accident compensation plan under the umbrella of one institution provides opportunities for the provision of consistent, co-ordinated and improved rehabilitation services to all accident victims. It also permits a rational and coordinated approach to accident prevention. The statistics compiled under such a scheme give a clear picture of accident rates and incidence across all societal activities. Problems can be quickly identified and remedied by a combination of education, incentive or penalty schemes or further statutory regulation.

However, in New Zealand both rehabilitation and accident prevention have been underfunded, and full advantage has not been taken of the scheme's potential as a rehabilitation and safety vehicle.

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Vennell, "Problems of New Zealand's No-Fault Accident Compensation Scheme", (1984), New South Wales Law Society Law Journal 44, p.47.

(k) New Inequities

The implementation of the policy of comprehensive entitlement for all accident victims has in turn created new inequities among the broader class of disabled persons. In New Zealand the accident victim has become a privileged sub-category of the disabled. It is difficult to draw rational distinctions among those who are disabled by accident, by illness and by congenital defects. And yet in New Zealand the benefits paid to the latter two through the welfare system are less generous than those paid by the accident compensation scheme. However, the implementation of an accident compensation scheme does not foreclose the possibility of further extension to all of the disabled when it is deemed feasible.

It would certainly appear that many observers are agreed that the New Zealand accident compensation scheme is far superior to the system it replaced. It provides a much wider range of injured persons with a high level of income maintenance and other more moderate benefits. It provides those benefits, in the large majority of cases, efficiently, quickly and at a very low level of administrative cost. The overall cost of the scheme is moderate and certainly cheaper than retention of the pre-1974 system. Not only does it provide compensation benefits but it also actively assists, encourages and plans the rehabilitation of accident victims, and co-ordinates and promotes accident prevention and safety. The Corporation in carrying out these policies can develop the role of educator and ombudsman in the field.

This conclusion is supported by two commentators who have made a close study of the Accident Compensation Scheme. Mr. William Hodge, Senior Lecturer of Law at the University of Auckland, has written:¹

In eight years of operation the system has proven itself. No one wants to return to the bad old days. There is no demand from any quarter to abolish the system.

And according to Professor Ison:²

The new system of accident compensation certainly appears to be a success. It is better than the previous systems operating there and better than any other systems known to the writer that is operating elsewhere.

Some concern is expressed, however, about the comprehensive nature of the scheme. Margaret Vennell notes:³

It is argued that neither manufacturers' nor occupiers' lack of care can be adequately policed by methods of prevention largely because facets of accident are so wide: those close to the scene are in the best position to appreciate the likelihood of danger, and the fear of litigation and publicity will generate sufficient awareness so as to guard against breach.

1 Hodge, "No-Fault in New Zealand: It Works" (1983), *Ins. Conn. Jo.* 222, p.230.

2 Ison, Accident Compensation: A Commentary on the New Zealand Scheme (1980), p.187.

3 Vennell, op. cit., p.45.

In a paper prepared for the Task Force entitled "Economic Analysis of Fault and No-Fault Liability Systems", Professor Sam Rea highlights the advantages and disadvantages of the system as follows:

The advantage of the New Zealand system is that it eliminates the overlaps and gaps that arise when coverage is piecemeal. This not only makes the insurance coverage more rational, it also eliminates the administrative cost of allocating accident costs to different sectors. The disadvantages of this general approach are twofold: first, the costs of accidents are not as effectively imposed on those engaged in risky activities, and second, the moral hazard (exaggerated claims) may be greater in some sectors than in others. The efficient response to moral hazard is to provide less generous coverage in situations where the moral hazard is greater or to invest more resources in analyzing claims. The tort system invests substantial resources in determining the magnitude of losses and allocating costs between individuals (or firms) and activities. These two concerns must be weighed against the obvious administrative advantages of having a universal system.

APPENDIX 16

THE CURRENT SYSTEM OF DISABILITY BENEFITS IN ONTARIO*

The present system is a shared federal-provincial jurisdiction and can be divided into three classes of programs:

1. The general disability programs are those which provide benefits without regard to the cause of disability. They include the C/QPP, private Long-Term Disability (LTD) insurance plans, and social assistance including provincially sponsored programs for disabled persons.

In Ontario, the Ministry of Community and Social Services provides a monthly cash allowance and other benefits (GAINS-D) to individuals and families in need of long-term financial assistance and to the elderly, disabled, blind, or parents raising children alone. The amount of the allowance varies with the size of the family, ages of the children (if applicable), living circumstances and other special needs. A certain amount of employment earnings is allowed without affecting the cash allowance.

In addition, recipients of GAINS-D wishing to start full-time employment can receive assistance under the Work Incentive Program (WIN) administered by the Ministry of Community and Social Services. Depending on family size and earnings, qualified applicants may be eligible for monthly cash benefits for up to two years.

2. The categorical programs are those which provide benefits to those with specific conditions and/or in limited circumstances. These include the system of provincial workers' compensation programs, benefits for disabled war veterans, the automobile accident insurance system and criminal injuries compensation.
3. There are other benefits and provisions which are of direct importance in assisting disabled persons but which are not directed toward long-term income assistance. These include such programs as Vocational Rehabilitations of Disabled Persons, special income tax deductions and welfare services.

In Ontario, certain items of benefit to disabled persons are exempt from provincial sales tax, namely, specified artificial limbs and other prosthetic appliances, orthopaedic appliances, hearing aids and batteries for them, and equipment designed solely for the use of visually impaired or physically handicapped persons. In addition, the purchase of a motor vehicle used to transport someone permanently disabled is eligible for a sales tax rebate, and special arrangements are available to a disabled individual, family member or religious, charitable or non-profit organization providing this transportation. Finally, municipalities can provide such special items as prostheses and wheelchairs to those eligible under the General Welfare Assistance Program.

* Much of this background is taken from the Main Report of the Joint Federal-Provincial Task Force on a Comprehensive Disability Program (September 1983), with appropriate updating, and references to Ontario.

The strengths of the current system can be enumerated as follows:

- o basic protection for almost all earners against total disability through the C/QPP; much higher for individuals covered by LTD;
- o good protection against on-the-job injury and automobile accidents;
- o provincial assistance programs ensuring a minimum level of income;
- o a comprehensive program of vocational rehabilitation services for disabled persons;
- o an effective medical care system;
- o protection against short-term disability.

Despite these strengths, there are many problems with the current system arising from limitations in individual programs and broad gaps and inconsistencies in the overall protection afforded by the system as a whole. The major problem areas are threefold:

1. Determination of Disability

Because of different objectives, the various programs define "disability" in very different terms. The C/QPP and LTD provide benefits only for total disability. Workers' compensation provides benefits for work-related injury and illness, but it is often difficult to decide whether or not (and to what extent) one individual's illness is work related.

Partial disability benefits pose difficult problems in determining the degree of disability. In Ontario, the workers' compensation program uses an estimate of earnings loss, requiring a more active "hands on" administration.

2. The Population Protected

The existing system has both gaps and overlaps in coverage. The major gaps are:

- o There is little protection for non-earners with the exception of provincial assistance, the legal system and private insurance.
- o The benefits provided by C/QPP are relatively low and payable only in the event of total disability. (Note, however, the recent improvements to CPP benefits involving an increase in the flat-rate disability benefit from \$87.56 to \$224.40 (1985 rates), thereby raising the maximum CPP disability pension from the current level of \$414.13 to \$550.87. In addition, the labour force requirements are being eased to include those who have worked for two of the last three years or five out of the last ten.)
- o Workers' compensation is restricted to job-related disabilities.
- o LTD plans cover only about 43% of the employed labour force and, in the long term, only for total disability.

Overlapping coverage occurs when a disabled person could be eligible for benefits from more than one program. In most cases, this does not result in excessive benefits because one program offsets the benefits of the other. Thus LTD programs offset any C/QPP benefits and, for example, the recent CPP benefit improvement described above will result in a \$17 million reduction in Ontario GAINS-D expenditures. (Currently about 15% of GAINS-D recipients out of a total caseload of 60,000 also receive CPP disability benefits.) In addition, workers' compensation in Ontario integrates or offsets CPP benefits to some extent. Overlapping coverage raises the administrative costs of the system, and duplication of medical forms and examinations is a recurring irritant which frustrates claimants and their physicians. A more integrated, comprehensive system could alleviate these problems.

3. Adequacy of Benefits

- (i) While initial benefit levels are relatively high for totally disabled earners receiving workers' compensation (for on-the-job injuries), or private LTD, the CPP benefit is much smaller and is insufficient on its own to prevent a serious drop in living standards in most cases. Also, workers' compensation and CPP are both subject to earnings ceilings which tend to limit protection for workers with above-average earnings. Provincial assistance programs such as GAINS-D, WIN and GWA are directed at providing for minimum income needs.

Currently, in Ontario, there is a startling and unacceptable discrepancy between levels of benefits under GAINS-D and GAINS for the aged (GAINS-A). As of January 1986, a single person eligible for the GAINS-A guarantee will receive \$707.15 per month, while a single GAINS-D recipient receives only \$436.00.

- (ii) Inflation provisions are strongest under the CPP (full indexation) and poorest in LTD plans. Only recently has Ontario tied workers' compensation to increases in the Consumer Price Index, while GAINS-D and WIN remain subject to ad hoc provisions only. (Note that GAINS-A is fully indexed.)
- (iii) Special needs associated with disability are provided for by workers' compensation, GAINS-D and WIN; however, they are ignored under the CPP and only partly taken into account under LTD plans.

APPENDIX 17

The Potential Effect of Liability
Claims on the Canadian Public Health
Care System: A Need for Legal Reform
and/or an Alternative to Litigation
for the Compensation of Persons
Disabled Because of a Medical Misadventure

Frank J. Sellers, B.Sc.(Med), MDCM, FRCP(C)

Note: The Task Force did not commission this paper, but was made aware of it in the course of the Task Force's activities. In view of the importance of the subject and the analysis therein, the Task Force is grateful to the author for his permission to reproduce the paper in its entirety.

This report reflects the views of the author
and not necessarily those of the Department
of National Health and Welfare.

INTRODUCTION

Evidence is accumulating which suggests that the number of complaints made about the medical care received by the public is increasing and that the number of malpractice claims against physicians, hospitals, hospital employees and the health products industries is increasing in Canada.

Furthermore, it would appear that the size of malpractice settlements is also increasing.

Costs to the public health care system are both direct and indirect. Some of the costs are readily identifiable whereas others are not.

Today's true costs may not be known for several years because of the «lag-time» between injury and compensation following litigation.

Much of the evidence that the current litigious atmosphere may be deteriously affecting our health care system is anecdotal and much is derived by analogy from the U.S. experience in recent years. Concern is being expressed that Canada has begun to follow the pattern that has occurred in the States. Awards and settlements in Canada have now reached the levels of those in the U.S.A. even though Canada provides health care for all citizens. Americans are not as fortunate and a large portion of American malpractice awards must go to pay for the medical care received.

pendix I The trend in the Canadian Medical Protective Association (CMPA) fee rates is interesting. The CMPA is a professional liability association to which over 85% of all doctors in Canada belong. Until 1983, the CMPA was able to provide a uniform fee-for-membership to all physicians. 'Because of a precipitous drop in their excess revenues over expenses in 1983, it was found necessary to carry out an actuarial study of the litigation risks for all types of physicians. As a result, physicians were classified by specialty and the membership fee became dependent on the specialty classification in 1984.

The fee schedule was not increased during 1985 but, because of an increase in the number of malpractice claims and because of the size of awards, it was found necessary to increase it again in 1986.

Appendix II

The escalation in the «Average Award» is plotted on the next graph. The 1984 figure is an estimate because the CMPA no longer publish this statistic. It was necessary to calculate it from data that was available for a 13 month period. If you assume that 12/13ths of the amount is closer to the 12 month average amount awarded, the figure would be \$90,000 instead of \$101,000. It is interesting to note that the average award in the U.S.A. in 1975 was \$94,947 and that in 1984, it was \$338,463. The comparison causes some concern as to what the future may hold for this country particularly when it is known that writs have been issued for \$15 million and when it is known that awards of \$2 million have been handed down in 1985.

Appendix III

The next graph shows the total amounts paid out in Malpractice awards or, settlements by the CMPA on behalf of physicians from 1971 until 1984. The total amounts paid out by CMPA went from \$5.96 M in 1982, to \$10.97 M in 1983 and \$13.78 M in 1984.

Appendix IV

The next graph shows the legal costs for the defense of doctors by CMPA. As you can see the legal costs to the society have increased to \$7.4 million in 1984.

Appendix V

The next graph shows the revenues of CMPA from 1980 to 1984 together with the projected revenues for 1985 and 1986. Because CMPA is a professional association and not an insurance company, it is not required to set aside large reserves to cover expected losses. Approximately \$4 million was set aside in 1984 as a reserve and the rest was paid out in damages, legal costs and for administrative costs. The income in 1985 was projected on a basis of the 1984 income since there was no increase in the membership fees. In 1986, there is to be a fee increase which I estimate will increase the revenues to \$44 million. My estimate was calculated on a basis of the fee increase, knowing the effect of the 1984 increase and assuming that there was proportionally the same number of doctors in each category. It would seem to me therefore that the cost of «liability insurance» for Canada's 40,000 doctors in 1986 will be approximately \$44 million. This, in effect, represents a cost to Canada's health care system for physician malpractice protection. As such costs escalate it can be assumed that it will be reflected in the re-negotiation of provincial fee structures for physicians.

Appendix VI

Can we expect not only an increase in the size of the awards but also in the numbers of awards? the next graph shows a progressive increase in the number of writs served against physicians for 1971 to 1984. Despite the «crisis» which occurred in the U.S.A. in the mid '70's, there was no

corresponding increase in the number of legal actions against doctors in this country. However, Canada began to see an increase in the 1980's. By 1982, 516 doctors were involved in litigation, this rose to «over 700» in 1983 and 1266 in 1984. When speaking to the Executive Secretary of the CMPA and to their legal council, the expectation is that there will be more than 1500 doctors involved in new law suits in 1985. If you use the 1984 figure, 1 doctor in 30 was involved in liability litigation (for comparison purposes 1 in 12 doctors was said to be involved in a legal action in the U.S.A. in the same year).

pendix VII

The next graph shows the disposition of liability claims for 1978-84. The great majority were settled out of-court but when action proceeded to trial few have succeeded. When the Secretary Treasurer of the CMPA was questioned about the number of settlements, he maintained that it did not imply diminished standards of care but was due to the difficulty of their medical advisors to say without qualification that care was without reproach. He feels that their medical advisors give the CMPA «expert» opinion and not an opinion based upon the expected standards of practice. He said that the usual initial response of their experts, following a review of a case, was that there were no problems with the quality of care provided. However, when asked whether they could support that opinion unequivocally in court in the face of an expert opinion for the claimant, they would then qualify their response. This would suggest that it may be difficult to support a defendant and that it has become more difficult to disprove negligence in the tort system. As medical care becomes more and more complex, it will become increasingly difficult to support a medical act without qualification. If this is so, we can expect more suits will succeed. In the context of this data, you should keep in mind that the CMPA say that approximately one-half of legal actions against doctors are brought to a conclusion in each year by means of a dismissal or, discontinuance without an award or, settlement at the present time.

In the institutional and health products industry sectors concern is being expressed about the escalation of the costs of liability insurance premiums. Connaught Laboratories and the Canadian Red Cross have had difficulty in negotiating insurance coverage. It has not been possible to obtain insurance for the fractionation of blood products which is done by Connaught for the Red Cross.

Vaccine product liability has become a major issue for Connaught Laboratories in Canada as well as in the United States. Connaught is one of the few suppliers of vaccines in the world and although untoward effects of inoculation are rare, litigation has become a significant problem. If Connaught should withdraw from vaccine production, this country would undoubtedly experience an epidemic recurrence of such illnesses as polionyelitis. This would result not only in a marked increase in acute and chronic health care costs to the country but also in an impairment of the quality of life of many citizens. The illness cost to the country could be enormous.

The public health units across the country — particularly in Alberta — have experienced difficulty in negotiating insurance coverage. Similarly volunteer agencies such as the Victorian Order by Nurses and the St. John's Ambulance have experienced difficulty in obtaining affordable coverage.

Last year, Gestas, the consortium that has insured both physicians and hospitals in Quebec withdrew from the market. The Quebec hospital sector hope to keep insurance costs to \$8.5 M for the fiscal year 1986 through self-insurance. The \$8.5 M figure was deemed necessary because this was the amount that it was going to cost if insurance was to be obtained from the commercial sector. In order to set up the self-insurance fund for hospitals, the Quebec government provided \$7.5 M directly.

The Canadian Hospital Association set up a «National Insurance Review Committee» which reported in April, 1986. This Committee has recommended a self insurance program with a «layer» of commercial insurance in excess of the self-insurance limit. As yet the «limits» of self-insurance have not been established. It should not be forgotten that the authors of the report, Marsh and McLennan, feel that the claims frequency and the cost per claim are expected to increase and that stability will not return to the commercial market in the foreseeable future. They also point out that self-insuring organizations in the United States have experienced the same problems as the commercial insurers. The recent claims experience of the Canadian Medical Protective Association tends to support this statement in this country. Because of funding mechanisms for Canadian hospitals, the source of money for self-insurance comes from the provincial governments and from federal sources through transfer payments.

Currently the clinical pharmacologists in Canada are unable to obtain liability insurance. Other investigators such as the oncologists, gastro-enterologists and cardiologists who carry out clinical trials do not carry liability insurance. Their funding sources are becoming concerned that they do not do so. If economic incentives should be introduced to encourage international pharmaceutical firms to increase their activity in Canada, it would be expected that Canadian research workers would participate. Clinical drug development work carried out under the auspices of a drug house will increase the liability of the universities and the hospitals. It may also increase the liability of the Medical Research Council, the National Cancer Institute and the Canadian Heart Foundation. In the last analysis, if product liability insurance is not obtainable at reasonable rates, it is doubtful that the international pharmaceutical firms can be encouraged to increase their presence in this country and hoped for economic gain will not be achieved.

Appendix VIII

The next graph shows the liability coverage statistics for 147 hospitals in Ontario — approximately one-half of the total number in the province. It shows the premiums paid from 1978 to 1985 and the expected premium from 1986. The slide also shows the «losses-to-date» suffered by the insurers and the «expected ultimate losses». The loss-to-premium ratio calculated on the experience to date varies from 102% to 327%. The expected ultimate losses-to-premium ratio is from 465% to 846%. The calculation of the premium for coverage beginning in June, 1986 is on a basis of the ultimate expected loss for 1985 which is \$6.9 million and adjusted for an inflation factor of 30% for 1986. My understanding is that the international re-insuring agents have tolerated low premiums until now in order to be competitive. They have been able to withstand deficits on their premiums because of high interest rates on their investments. However with the worldwide fall in interest rates, their reserves have fallen and they can no longer tolerate the low premiums which they have charged in the past. Interestingly they are treating Canada as part of the North American market in the belief that the liability situation in Canada is not significantly different from that of the U.S.A. Another reason for this high inflation factor of 30% is that the average time for malpractice litigation to be settled has increased from 3 or 4 years to 7 years. Insurance companies are required to maintain reserves against claims made-to-date and because the period of time between when a writ is issued until the final settlement has become longer, larger and larger reserves must be maintained, the «long-tail» effect of an increasingly litigious society is making it more difficult for national and international insurers to calculate their actuarial risks.

The question must be asked whether the Ontario Statistics for 147 hospitals could be extrapolated to indicate the increased costs of liability insurance for all hospitals across the country. The Ontario Hospital Association suggested that the 147 hospitals for which they had liability coverage statistics were a representative sample of all hospitals in the province. A survey of the Provincial Hospitals Associations and/or the Provincial Ministries of Health was done and it would appear that the liability insurance premiums across the country increased from 350 to 1200% with a clustering of around 900% in 1986. Since there are 1029 public hospitals in Canada, it would appear that the cost to the Canadian health care system for increased liability insurance may be in the neighborhood of \$50 M for 1986. It should not be forgotten that the insurance industry expect the escalation in costs to continue.

In a discussion of health care liability, it must be recognized that the legal system is adversarial. When discussing physician liability, the parties to a legal action most frequently include not only the doctor but also the hospital in which the medical act occurred. The majority of medical acts which result in a liability claim occur in hospitals. Because the insuring agent for hospitals is different from the insuring agent for physicians, there is a tendency for hospitals to deny responsibility for the actions of doctors on their staff. This pits the hospital against the doctor and consequently the CMPA has advised their members to refrain from discussing a legal action with the lawyers for the hospital. It should be recognized that it is the doctor who most frequently has the information which would allow the hospital to protect itself but in providing the information to the hospital, the doctor does not have any assurance that the hospital will protect him. It would seem to me that this adversarial approach deflects attention away from the responsibility of society to compensate the patient and the social responsibility of both the doctor and the hospital to maintain and improve standards of care. The adversarial approach induces a «we-and-they» situation which denies the thesis that improved health standards depends upon a team approach by health care professionals and by the institutions in which they work. Because of the threat of litigation to both the hospital and the physicians, peer review and quality assurance programs are not effective and cannot be unless there is a change in the relationship of physician to the hospitals in which they work and until the reporting responsibilities to the professional regulatory authorities are improved.

I have suggested to you that there is a need for re-thinking our present system for the compensation of the medically disabled because of the apparent costs to our health care system. I would also suggest that, at the present time, every Canadian does not have an equal opportunity to be compensated because legal action must be initiated, it costs money and there is no assurance that compensation will be achieved unless negligence is proved.

What are the solutions? I would suggest that there are two:

- (1) Tort Reform
- (2) The development of an alternative to litigation for the compensation of the disabled.

Let's look at Tort Reforms which would be intended to control costs and speed the provision of compensation for the disabled.

Statutes of Limitation: Such statutes are seemingly unpopular in Canada. My understanding is that British Columbia does have provision for Statutes of Limitation and that Nova Scotia is considering them. I however feel that they should be carefully considered. If the concept of medical liability litigation is retained, surely physicians, hospitals and the health products industry should not be held accountable for events that have occurred some 20 years ago. The standards of health care have changed and are very different from what they were at that time. According to the CMPA, the third most common cause of malpractice litigation is obstetrical negligence causing brain damaged infants. Recently there has been an alarming number of legal actions alleging obstetrical negligence as a cause of neurological deficits. Some of these claims resulted from births that occurred in the 1960's. Such actions make it difficult for insurers to calculate their actuarial risks, and for doctors, hospitals and the health products industry to defend themselves.

Collateral Source Payments: The collateral source rule prevents a defendant in a liability action from taking advantage of payments which the plaintiff may have received from another source (e.g. disability insurance, welfare payment, re-training programs, etc.). It has been suggested by Mr. Justice Montgomery of the Ontario Supreme Court that this rule should be re-examined in light of the Supreme Court of Canada's opinion that there is «need to compensate a plaintiff only for his actual loss and to provide for his actual needs».

Subrogated Rights: As with collateral source payments, there is, perhaps, a case for the rationalization of subrogated rights. According to the CMPA, in many malpractice cases, the bulk of the awards goes to satisfy the subrogated claim of a provincial health insurance plan for future health care. As doctors and hospitals are part of the cost of health care system, the payment of such subrogated claims, in the end, is charged back to the health care system.

Lump Sum Settlements: The most common settlement is a lump sum payment. Such settlements usually take into account the income tax that must be paid on the award. This is spoken of as the «tax-gross-up» of the award.

Another problem with such awards is that there is no guarantee how such awards are spent. They may be expended in a short period of time, following which the disabled person may become a charge on the state. Conversely they may not be totally expended by the disabled person for whom it was intended and instead will revert to a beneficiary at the time of death.

Structured Settlement: As an alternative to the lump sum settlement, structured settlements have been recommended by such persons as the Chief Justice of Canada, the Honourable Mr. Justice R.G.B. Dickson. Structured settlements may be paid in the form of an annuity which would be tax free during life. Such a payment could be structured so that there was a periodic review which could be adjusted according to needs throughout life.

Contingency Fees: Until recently contingency fees were not allowed in Canada. Now, however, 9 out of 10 Canadian provinces allow them, although, most commonly, there is a court review of the reasonableness of the proposed fee. Such fees, however, may amount to 20%-30% of an award.

Pre-judgement Interest: Interest payment may be added to an award from the time an action is brought until the award is made. In a recent \$1.9 million award, it amounted to \$300,000. It is argued by the insurers, with some justification, that this encourages plaintiffs to prolong the litigation time.

Non-Economic (Pain and Suffering) Awards: Recent Family Law Reform Act changes have contributed to the escalation of malpractice awards. Although the Supreme Court of Canada placed a «cap» or a liability limit of \$100,000 on such awards, they have escalated to \$178,000 in terms of 1985 dollars. Such changes have meant that more family members — not just dependants — are eligible for compensation. Brothers, sisters, parents and husbands of adults who have become disabled have received compensation in recent awards. It would appear that malpractice awards have assumed a different purpose from which they were originally intended — the provision of continuing care of the disabled.

It would appear that the Civil Liability System for the compensation of the disabled is cumbersome, complex and expensive. The increasing cost to Canada's health care system is due both to an increasing litigious attitude of society and is also due to the premium rates changed by international re-insuring companies. Characteristically insurance premiums have undergone cyclic variations and at the present time they are undergoing inflationary increases. This is expected to continue for the next 3 or 4 years following which a fall in the premium rates may occur. However, it is not thought that the base-line will return to previous levels and the net result will continue to be an escalation in the cost of liability insurance. Furthermore the legal system does not ensure that the disabled are compensated unless negligence can be proved. As well, the Tort System does not and cannot deal effectively with a health care professional who practices substandard care. Nor can it deal effectively with a negligent hospital, or negligence in the health products industry.

I believe that the issue of the compensation of the disabled should be clearly separated from the issue of the regulatory requirements for maintaining the standards of health care. This leads to the suggestion that an alternative to litigation for the compensation of the disabled be sought.

The idea of a compensation board or, arbitration board is not a new one. The role of the compensation board is to determine the degree of functional impairment and to structure a settlement. In the U.S.A. an arbitration board has been suggested. In Sweden and in New Zealand, compensation boards are in place. «No fault» compensation has worked to a varying degree of success in both countries for over 10 years. In Canada, the Associate Dean of Law of the University of Alberta, Professor Ellen Picard, is a proponent of a «better system for compensating patients.» Other respected members of the legal profession have expressed similar sentiments. Mr. Justice A.M. Linden, the President of the Law Reform Commission of Canada has expressed his regret that «patients who deserve compensation may be excluded from it because of the present requirements of tort law» and he has suggested «Canada should consider a social insurance solution.»

I believe the Compensation Board idea should be explored further. In exploring an alternative to litigation for the compensation of persons disabled because of a medical misadventure, tort reform should not be forgotten. Indeed Section 24 of the Canadian Charter of Rights may necessitate the continuation of the legal liability process. However a patient could forego his right to appear before «a court of competent jurisdiction» in favour of an appearance before an arbitration board with the assurance that compensation would be awarded according to the degree of functional impairment and not upon whether negligence was proved or not. The advantage to Canadian society and to the public health care system would be that the level and cost of compensation would become predictable. The concept of limited liability will have to be addressed if the universal and accessible health care system is to be preserved and remain affordable.

I would also suggest that the role of Regulatory Authorities should be strengthened. In the case of the professional Regulatory Authorities, I feel their role should be strengthened so that they can institute «preventive measures» to maintain standards of practice and, where there is evidence to suggest misconduct, incompetence or negligence, they should be given the regulatory authority to proscribe licenses, require re-education and re-certification and, if necessary, they should be able to decertify.

In this discussion, I believe attention should focus upon the primary underlying objectives. In my opinion these are:

- (1) the social responsibility of Canadian society to compensate persons who have become disabled so that they may enjoy a quality of life which would not be attainable if no compensation were available.
- (2) the responsibility and accountability of health care professionals, health care institutions and the health products industries to maintain and improve their standards.
- (3) the responsibility of the administrative structure of the health care system to ensure the efficient use of available resources.

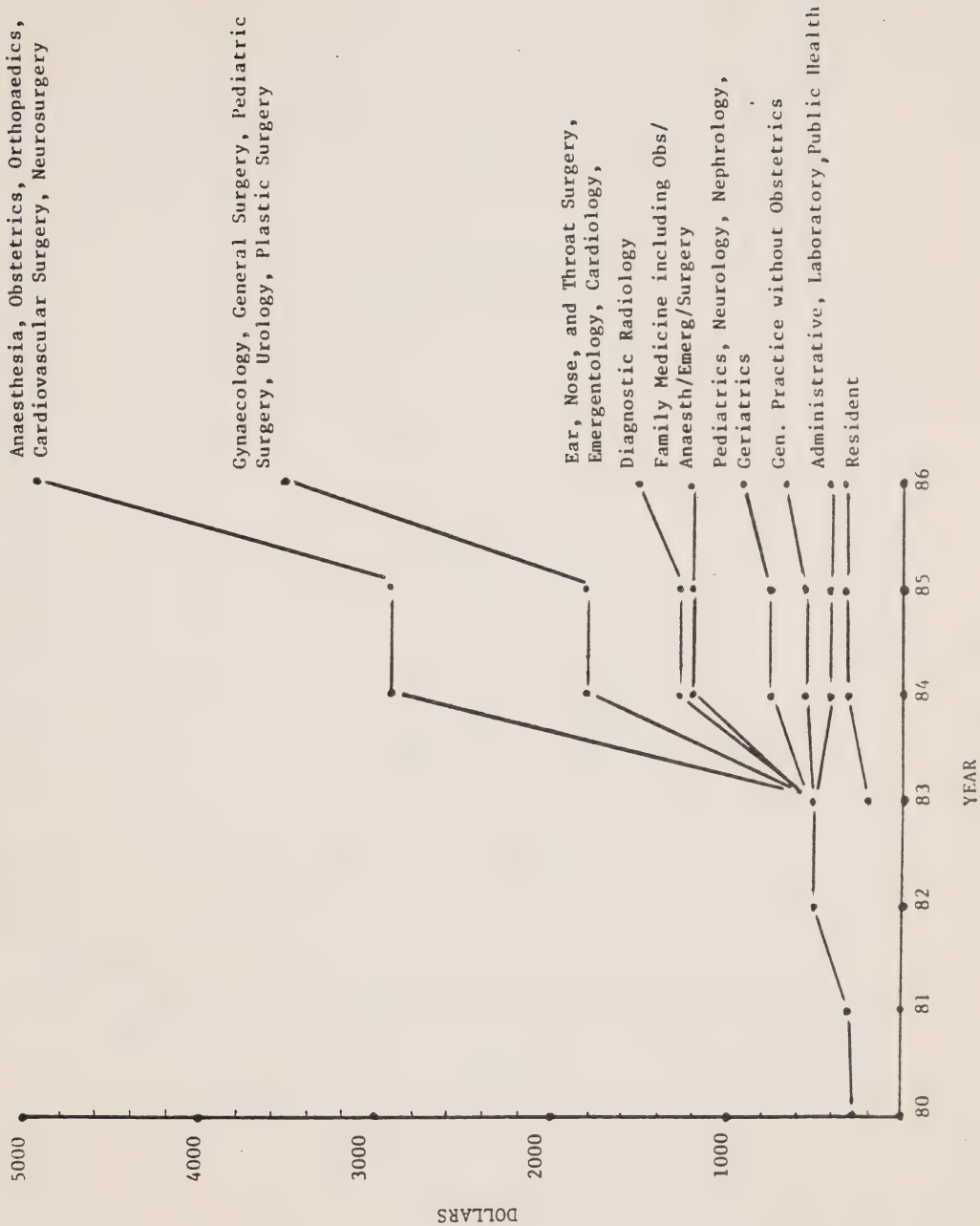
I would suggest that a careful look should be made of the current legal adversarial approach in order to determine whether it meets these objectives and requirements. If it does not, alternatives should be developed which would compliment existing mechanisms and which would be designed to serve and protect both the individual member of society as well as the public interest.

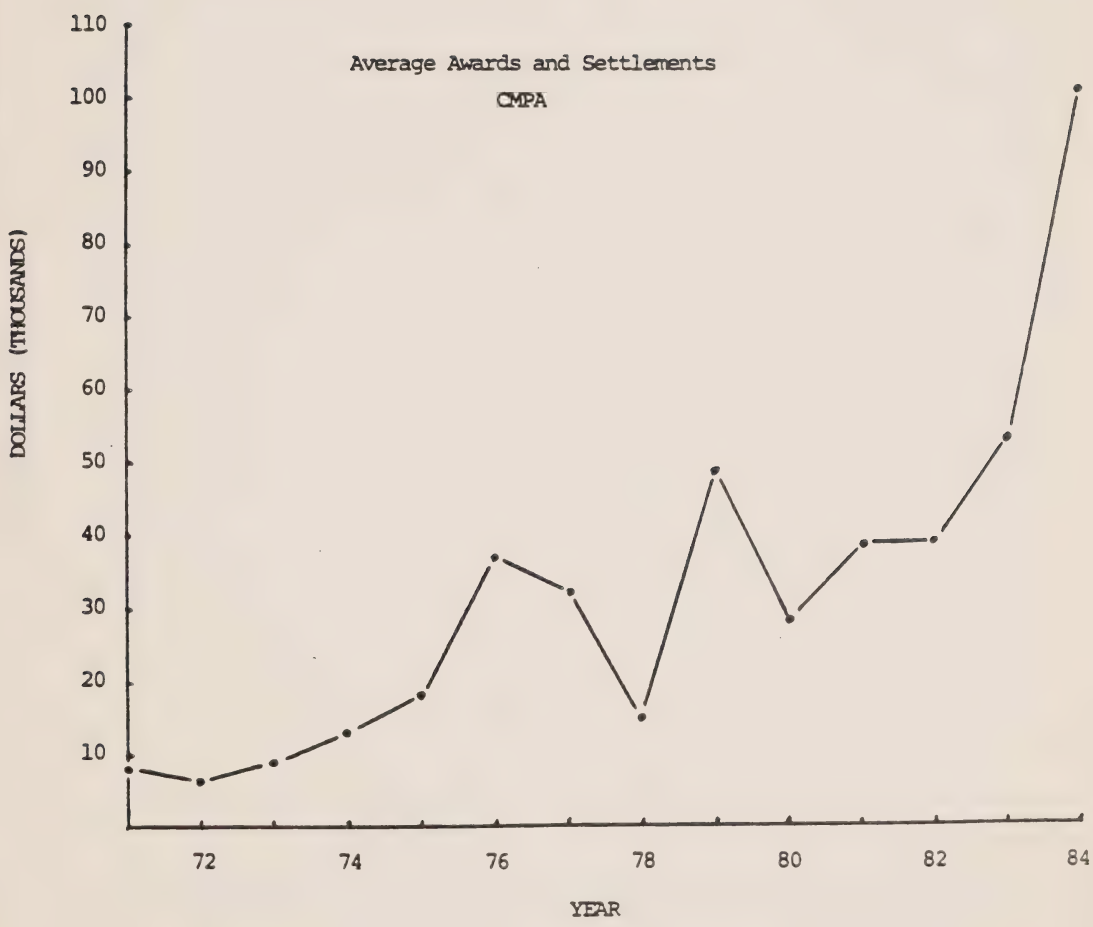
I would suggest that the problem is not just one of availability or affordability of liability insurance. I would suggest that it is primarily a problem of responsibility and accountability where there is public liability.

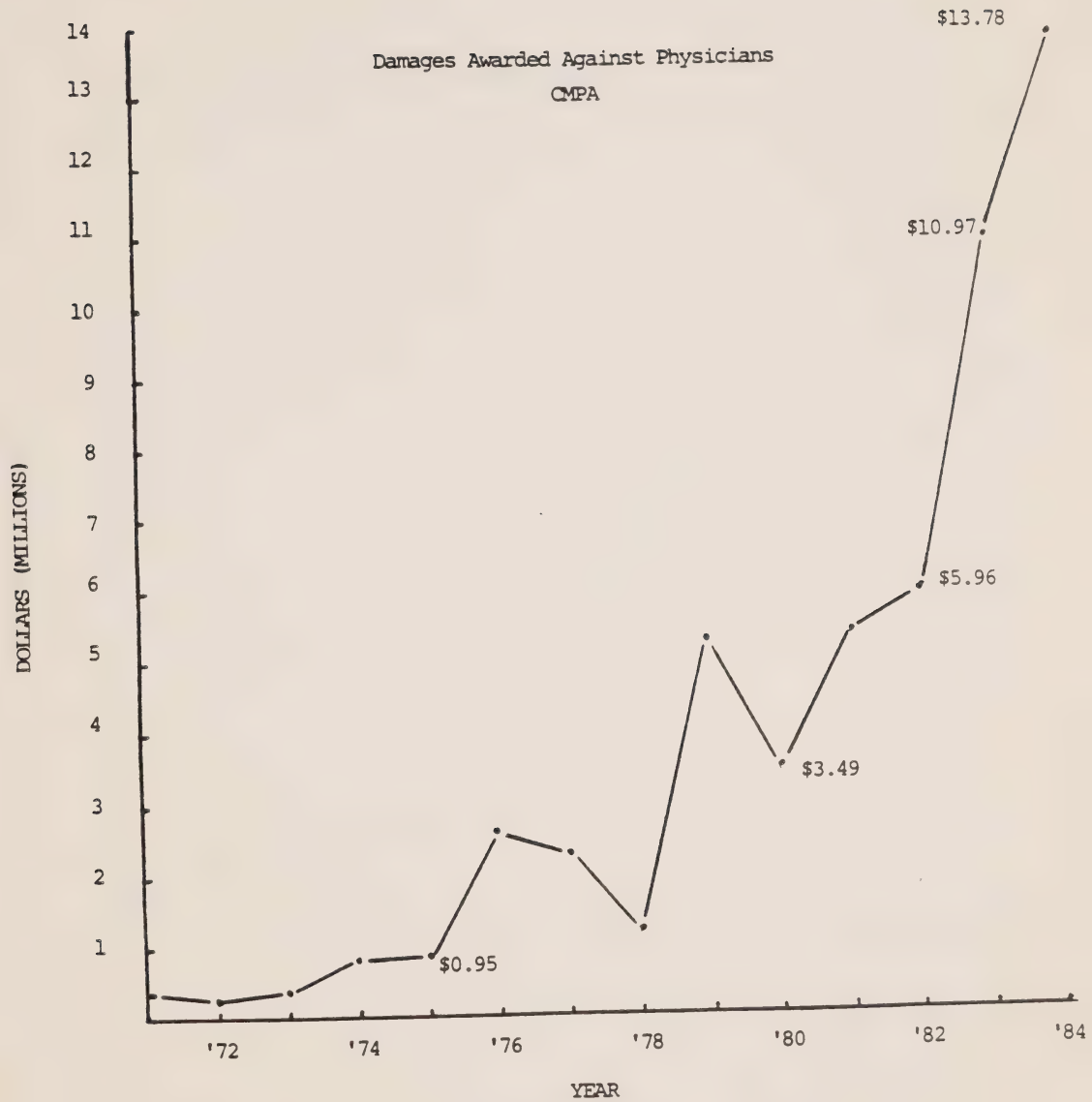
In the context of public liability, the issue extends beyond that of the public health care system. For example, accidents associated with the transportation industry may carry implications relative to the public liability issue. Highway, rail or airplane transportation of hazardous products may result in a liability problem. Regulation may limit this risk but nevertheless it will remain since, of necessity, the transportation of such products will continue. When such accidents occur, it would appear that there should be public liability which will include not only the provision of acute and continuing health care but also the compensation of the disabled persons.

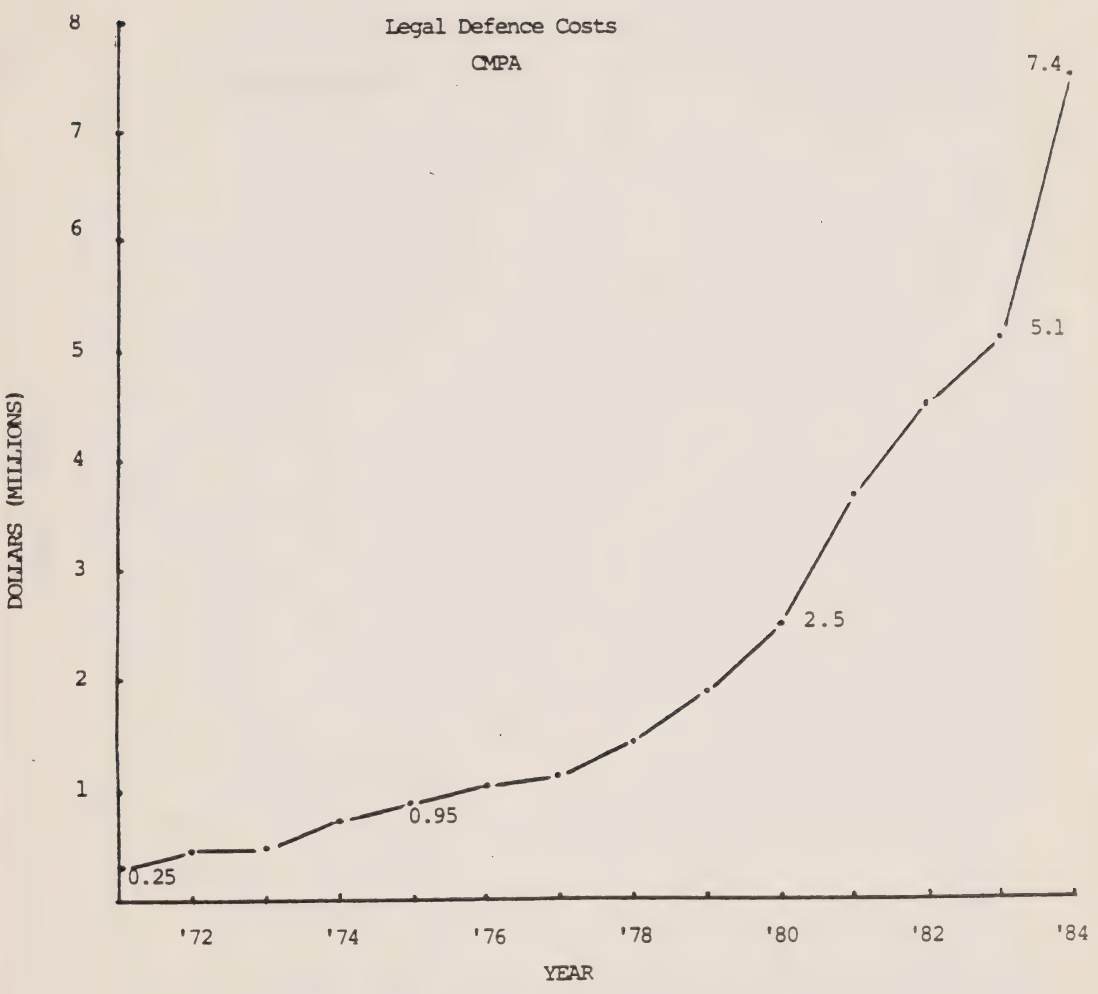
The provision of insurance may be a necessary short-term solution to a current crisis but a rationalization of public responsibility and accountability should be sought in order to provide a long-term resolution of the issue.

CMPA FEES

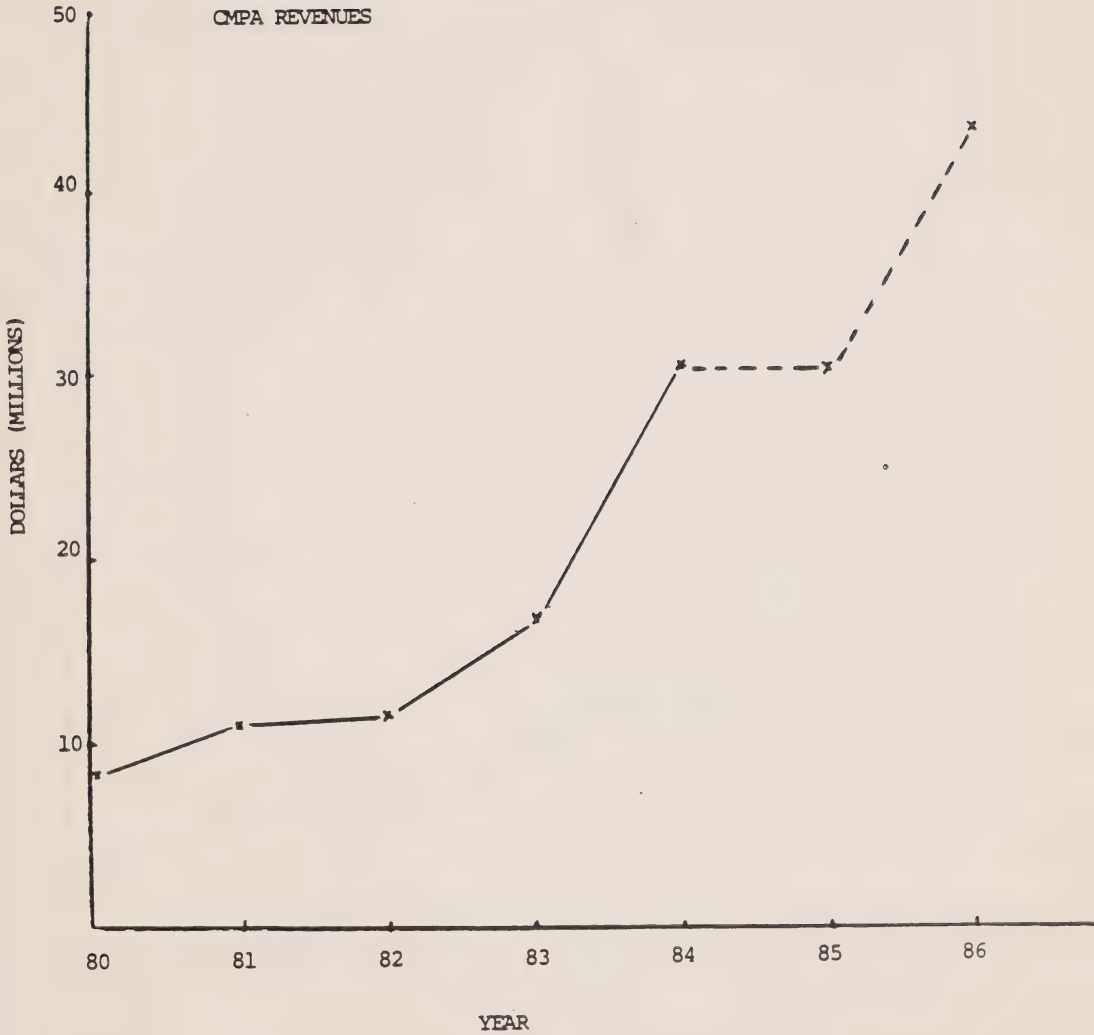




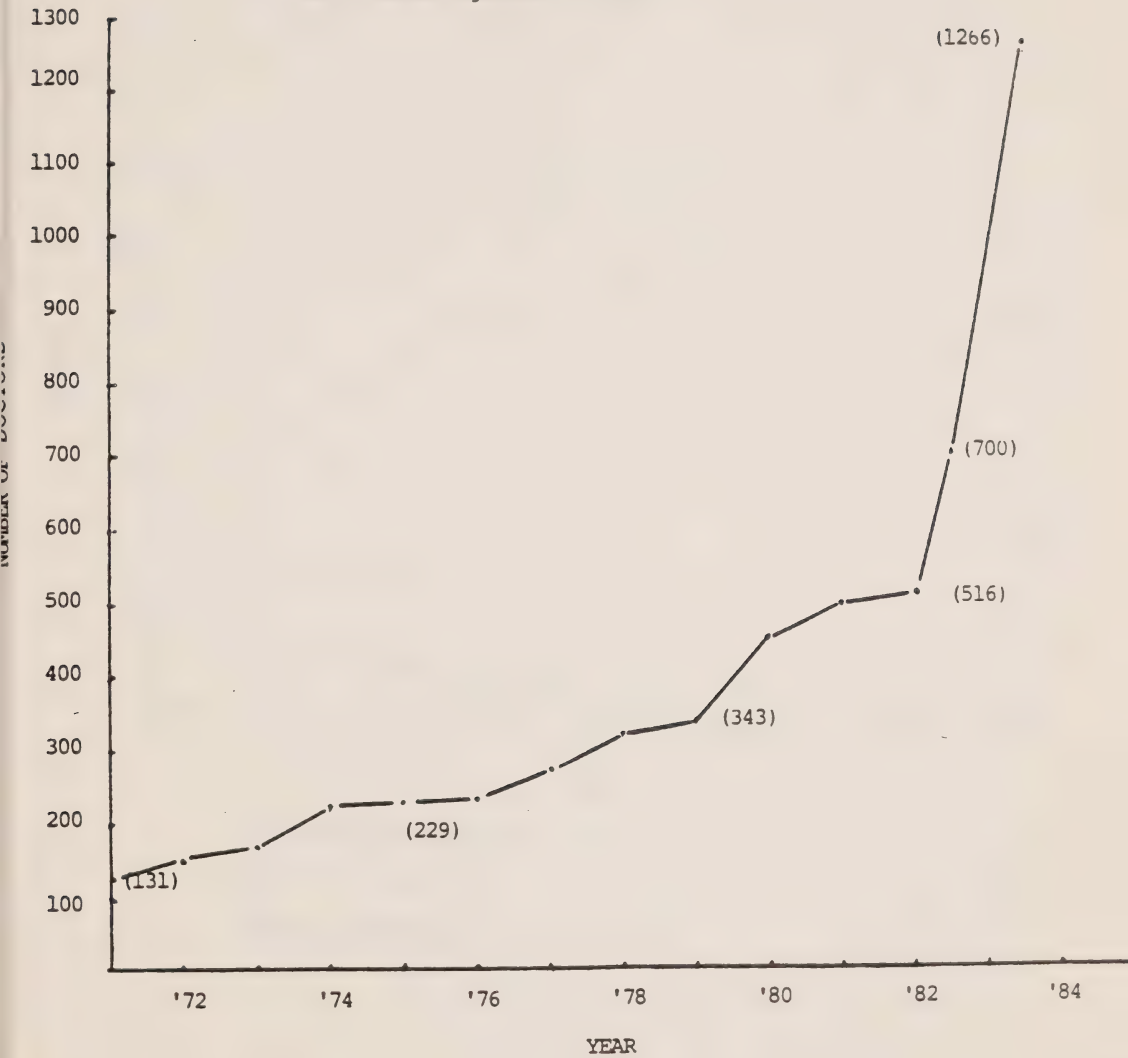


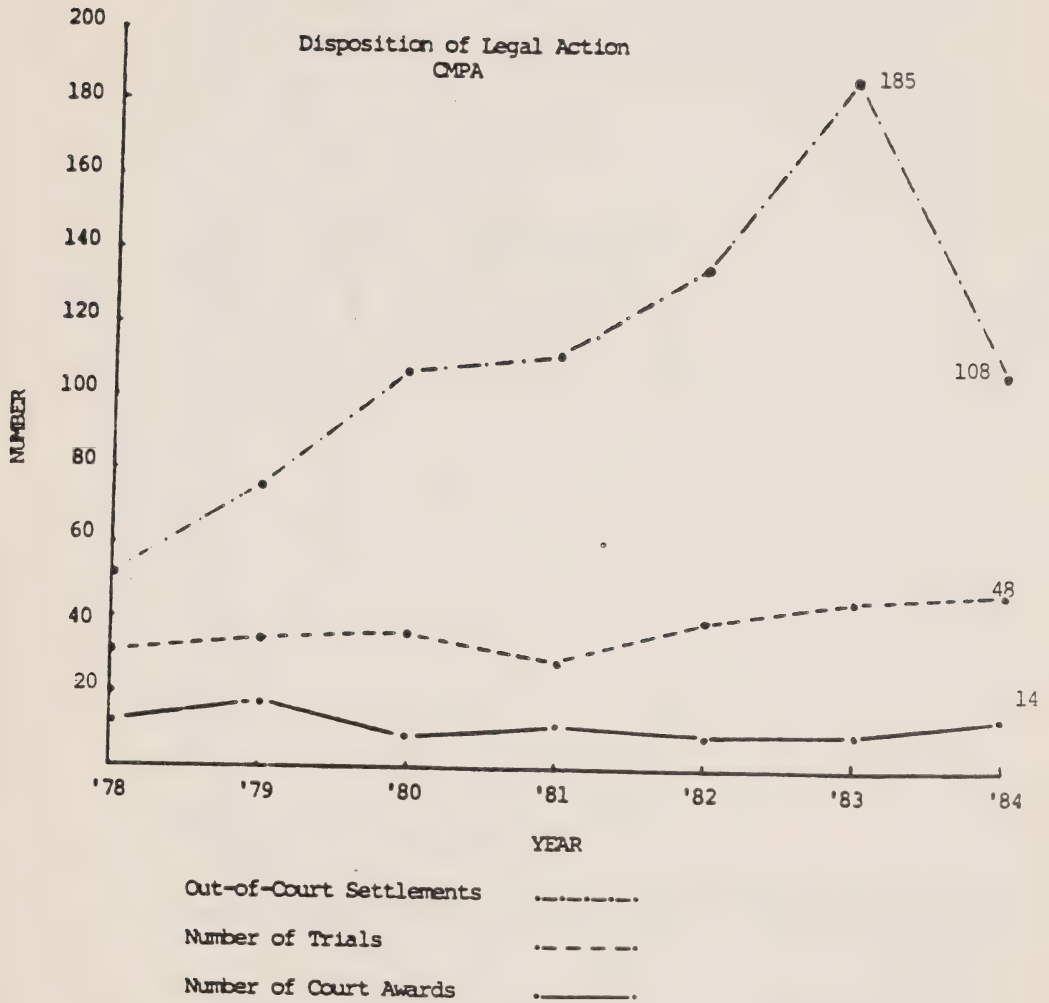


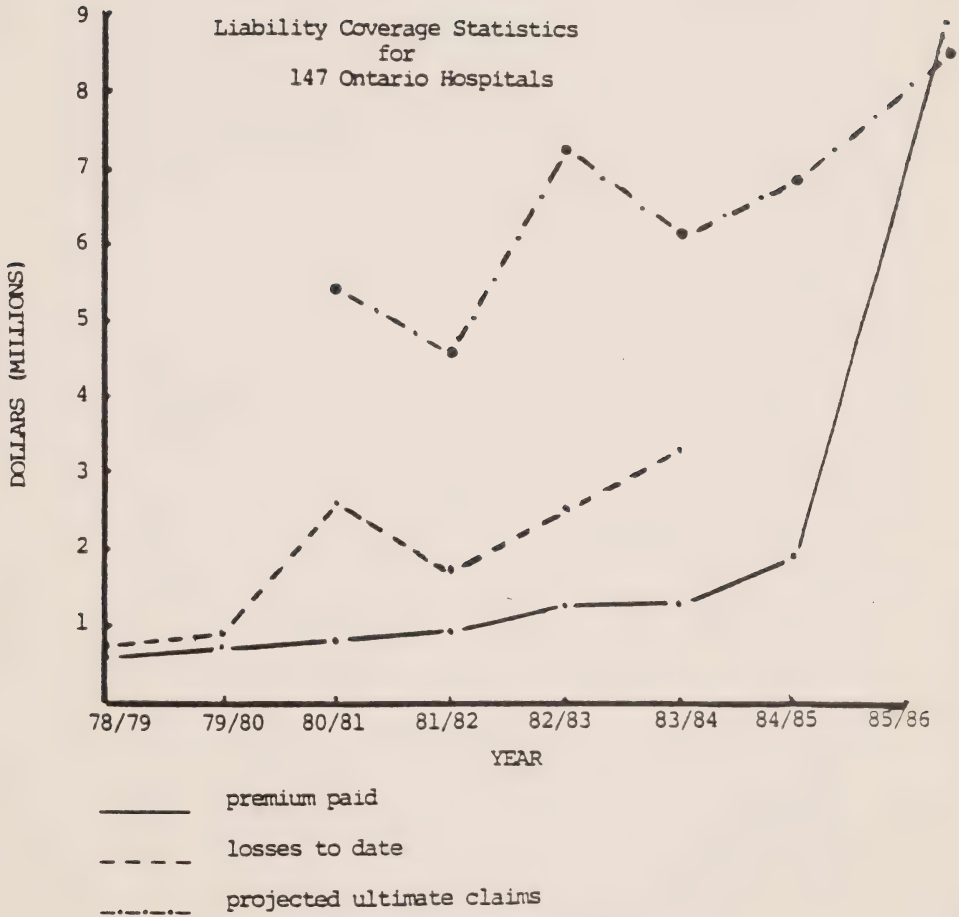
CMPA REVENUES



WRITS Served Against Doctors







APPENDIX 18

SUMMARY OF PROBLEMS AND PROPOSALS FOR REFORM SUBMITTED TO THE TASK FORCE, CLASSIFIED BY TYPE OF INSURED GROUP OR INDIVIDUAL

The Task Force received about 100 formal briefs and many more submissions from groups and individuals over the course of its mandate. The following material sets out, in summary form, the problems raised and proposals put forward in the briefs and submissions. It does not purport to be in any way comprehensive, and is intended only to indicate the wide range of individuals and groups who have obviously been deeply affected by the insurance crisis and to provide a snapshot of their concerns as presented to the Task Force.

(Note: No reference has been made to the concerns of and proposals put forward by architects and engineers, physicians and surgeons, health-care professionals, hospitals, accountants and lawyers since these are covered in depth in Appendix 10 dealing with professional liability insurance.)

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Manufacturers, Exporters, Retailers, Wholesalers, Small and Medium-Sized Businesses

- | | |
|---------------------|--|
| Problems | <ul style="list-style-type: none"> - Affordability and unavailability of liability insurance. - Huge increases in premiums especially for exports to the United States. - Most affected producers include: protective equipment, material handling equipment, machine tools, industrial brakes, cranes, scaffolding, medical equipment and devices, automotive after market parts, aerospace products, and sports product and clothing. - Small and medium-sized business more severely affected. - No insurance coverage for environmental impairment; coverage for sudden and accidental pollution available only from "Spills Bill" pool. - Lack of meaningful data on product liability experience, etc. IBC's Commercial Lines Statistical Plan less than adequate. |
| Consequences | <ul style="list-style-type: none"> - Export operations curtailed, loss of employment. - Businesses in extreme financial difficulties; some forced to close, increased unemployment. - Businesses operating without insurance. |
| Proposals | <ul style="list-style-type: none"> - Government to establish an export liability insurance program, preferably in conjunction with the federal government. The government could either assume a portion of the pooled risks or provide limited reinsurance without any element of subsidy to the pool. This would ensure no contravention of the GATT. - Civil justice reforms as suggested by CBA(O) to moderate size of average awards and settlements. - Captive insurers, self-insurance for larger commercial entities. This is especially useful for those with large environmental risk exposure and could possibly be made mandatory. - Pooling of risks among business with common characteristics. - Claims-made insurance but subject to statutory regulation. - Improved statistical base. In this connection, the IBC has developed a new general liability |

statistical plan that will be implemented in the near future. (Note: that the IBC has improved its Commercial Lines Statistical Plan somewhat through additional definitions of the causes of losses and better coding criteria. In addition, new schedule rating was implemented shortly after 1979 which is now represented in the IAO's Rapidscan service.)

Service Providers, Contractors, etc.

- | | |
|---------------------|---|
| Problems | - Affordability and availability of liability insurance and environmental impairment insurance. |
| Consequences | <ul style="list-style-type: none"> - Operating uninsured. - Inability to comply with conditions of contract requiring insurance, leading to loss of business. - Businesses in financial difficulties, some closing down. |
| Proposals | <ul style="list-style-type: none"> - Access to export liability insurance program where appropriate. - Captive insurers. - Self-insurance, higher deductibles, etc. - Government to require the collection of meaningful statistical data to facilitate more accurate rate setting. - Government to regulate rates and moderate increases. |

Directors and Officers

- | | |
|-----------------|---|
| Problems | <ul style="list-style-type: none"> - Availability and affordability of liability (errors and omissions) insurance. One firm, with no claims history, had its liability limit cut from \$75 million to \$15 million over two years, and its premiums raised from \$60,000 to \$650,000. - In both the United States and Canada, the role of corporate directors has changed significantly. Increased shareholder activism and changes in corporate law and securities regulations, in particular, have resulted in both directors and officers being subject to greater scrutiny and attention. Standard exclusions from D & O insurance are for clearly dishonest conduct, or cases arising from the breach of securities laws, and increasingly, for court actions by shareholders on behalf of the company. |
|-----------------|---|

- Directors and officers face an increasing number of suits involving allegations of breaches of occupational health and safety regulations.
 - Brokers say there are currently only two main sources of D & O left in North America: American International Group, New York, and Encon Insurance Managers Inc., Ottawa.
- Consequences**
- Increasing reluctance of persons to serve as directors and officers, leading to a loss of capital and executive expertise.
 - Increased cost of insurance passed on to the consumer of the corporation's products or services.
- Proposals**
- Carrying on business without insurance, but this exposes the firm to considerable financial risk.
 - Form a captive insurer (appropriate only for large firms).
 - Reciprocal insurance exchange.
 - Self-insurance, increased deductibles.

Radio and Television Broadcasters, Print Publishers, News Producers, et al.

- Problems**
- Affordability and availability of libel and slander insurance.
 - Several insurers have withdrawn from underwriting errors and omission insurance (libel and slander). One broadcaster was able to obtain a new policy for a premium of \$29,422, subject to a deductible of \$25,000 for each occurrence. This represented an increase in premium of 1,950% from the previous level of \$1,500.00 per annum, and an increase in deductible from \$2,500 per occurrence to \$25,000. The broadcaster had never received any notification of libel from any plaintiff and had never been sued.
 - High court awards in the United States are usually cited by insurers as explanations for the dramatic premium increases. But a recent Quebec Court of Appeal decision in Snyder vs. Montreal Gazette Limited reduced an exorbitant \$135,000 award for moral or non-pecuniary damages in a defamation action to \$13,500, and it is expected that the Supreme Court of Canada will confirm this effective "cap". Hence, Canadian courts do not appear to be susceptible to the American trends.
- Consequences**
- Severe financial restrictions leading to the termination of some businesses.

Proposals

- A reciprocal insurance exchange to cover libel and slander exposure.
- Self-insurance
- Improved loss prevention and control.

Municipalities**Problems**

- Affordability of liability insurance.
- Availability of insurance for community groups, recreational facilities etc.
- Availability of insurance for volunteers.
- Insufficient numbers of insurers.
- Annual tendering of insurance contracts to lowest bidder.
- Purchasing property insurance and liability insurance separately.
- Problems in obtaining environmental impairment coverage; coverage for sudden and accident pollution provided by the "Spills Bill" pool is too limited.

Consequences

- Increased taxes.
- Curtailment of recreational facilities, etc.

Proposals

- The preliminary report of the Municipal Affairs Insurance Advisory Committee has put forward the following recommendations:
 1. The Committee recommends that the Provincial Government fund a study dealing with the information provided in the Municipal Liability Insurance Information Survey that would perform the aforementioned tasks and such other tasks as the Committee deems appropriate.
 2. The Committee recommends that the feasibility be determined of establishing a fund that would remove the necessity of purchasing coverage in excess of an operative level of insurance.
 3. The Committee recommends that the Minister of Consumer and Commercial Relations move quickly to establish the Canadian Insurance Exchange.

4. The Committee strongly recommends that the Attorney General consider municipal concerns, as expressed in a resolution of the Association of Municipalities of Ontario (AMO), when re-drafting the Limitations Act. AMO's concerns include:
 - . retention of the three-month limitations period for claims based on non-repair of public highways;
 - . retention of current notice provisions for claims based on non-repair of public highways;
 - . "capping" of limitations period for claims brought by persons suffering a disability at 10 years;
 - . exemption from abolition of prescriptive easements for municipalities and public utilities; and
 - . no adverse possession of lands vested in a municipality.
5. The Committee recommends that the Task Force on Insurance consider a revision of the joint and several liability provision in the Negligence Act that would restore the fundamental concepts of the tort system.
6. The Committee believes that, much like the speed limit signs that are posted at given points in the municipality advising motorists of the limit, unless otherwise stated, signs limiting permission or prohibiting the use of municipal lands, unless otherwise posted, would be as practical as, and substantially less costly than, the current requirements.
7. The Committee recommends that the Ministry of the Environment undertake an information campaign for all sectors of the community to provide a better understanding of Part IX of the Environmental Protection Act ("Spills Bill") and the Association Pool.
8. The Committee recommends further investigation in the field of risk management and that educational and promotional programs be made available to the municipal sector, so as to assist in the effective implementation of a risk management program tailored to municipal requirements.
10. The Committee recommends that the Task Force on Insurance consider a similar system

for all liability claims, fully recognizing that it may require some time to establish a credible data base upon which to determine an adequate level of compensation.

11. The Committee recommends that a statutory requirement be enacted to establish for municipal insurers a standard system of reporting to the Superintendent of Insurance, similar to that which exists for automobile insurers, in order to provide a consistent statistical base.
12. The Committee also recommends that the Provincial Government, in cooperation with the Association of Municipalities of Ontario and the major municipal insurers, prepare mandatory standard municipal liability insurance policies, which must be used when quoting on all municipal insurance policies.
13. The Committee believes that no further capping of awards is required.
14. The Committee recommends that the Task Force on Insurance consider some form of Good Samaritan Legislation that would protect Municipal volunteers.

Other proposals

- Appropriate amendments to the Municipal Act to require more adequate safety standards and inspections.
- Reciprocal Insurance Exchange.
- Self-insurance where appropriate. Note that Etobicoke, City of Toronto, City of York, Metro Toronto and the Borough of East York have already formed a self-insurance pool. Each is responsible for liability insurance for claims of less than \$10,000 and more than \$10 million. The pool then covers them for losses between \$10,000 and \$10 million.
- Better statistical and data base.
- Possible introduction of no-fault no-tort benefits for accidental injury below a certain threshold.
- Municipalities to be encouraged to insure both property and liability exposure with same insurer.
- Possible exemption from the Compulsory Automobile Insurance Act for municipalities that maintain adequate self-insurance funds for compensation of accident victims. This would be appropriate in the event that a reciprocal insurance exchange is formed that will be subject

to regulation by the Superintendent, and can therefore provide the safeguards envisaged by the Compulsory Automobile Insurance Act.

School Boards, Colleges and Universities

- | | |
|---------------------|--|
| Problems | <ul style="list-style-type: none"> - Affordability of liability insurance. - Availability of insurance for volunteers, sports and recreational groups, etc. - Availability of insurance for premises where alcohol is served. |
| Consequences | <ul style="list-style-type: none"> - Higher taxes. - Higher tuition fees for colleges and universities. - Curtailment of sports and recreational activities. |
| Proposals | <ul style="list-style-type: none"> - Much more systematic risk management and loss prevention programs. - Appropriate amendments to the <u>Education Act</u> and <u>Colleges and Universities Act</u> to establish adequate safety standards and inspection. - A reciprocal insurance exchange. (Note that this is now under serious consideration by the Ministry of Education on behalf of the school boards.) - Civil justice reforms to moderate awards and settlements. - Increased use of releases by participants in sports and recreational programs and events to limit potential liability. |

Day Care Centres

- | | |
|---------------------|--|
| Problems | <ul style="list-style-type: none"> - Affordability and availability of liability insurance. - Availability of insurance for volunteers. |
| Consequences | <ul style="list-style-type: none"> - Severe financial difficulties, possible closures. - Carrying on business without insurance. |
| Proposals | <ul style="list-style-type: none"> - Much more systematic risk management. - In-depth review of the standards of care, etc., provided for in the <u>Day Nurseries Act</u>. - Reciprocals, self-insurance. |

- Government to continue to support a liability pool, similar to the Facility Association mechanism, to provide residual insurance coverage where none is available in the private market.
- Much better statistical base to provide meaningful loss experience to facilitate premium setting.

Utilities

- | | |
|---------------------|--|
| Problems | <ul style="list-style-type: none"> - Affordability of liability insurance. - Availability of environmental impairment and "sudden and accidental" pollution coverage. |
| Consequences | <ul style="list-style-type: none"> - Increased cost of insurance passed on to consumer. |
| Proposals | <ul style="list-style-type: none"> - Self-insurance, increased deductibles, reciprocals, captive insurers. - Perhaps mandatory reserves (tax deductible) for major environmental risks. - "Spills Bill" pool for "sudden and accidental" pollution insurance coverage. - More emphasis on risk management and loss prevention. |

Tavern Owners, Hotels and Motels, Other Business Persons

- | | |
|------------------|---|
| Problems | <ul style="list-style-type: none"> - Availability and affordability of liability insurance, particularly in respect of premises where alcohol consumption is permitted, and occupiers' liability. - Little or no notice of non-renewal, mid-term cancellations, or huge premium and deductible increases. - Unrealistic demands for up-front payments of annual premiums. - Expanded duty of care imposed on owners with respect to invitees on their property. |
| Proposals | <ul style="list-style-type: none"> - Carrying on businesses without insurance. - Regulation of minimum notice periods for non-renewals, mid-term cancellations and increases in premiums and deductibles. - Self-insurance, increased deductibles. - Civil justice reforms to moderate awards and settlements. - Caps on awards. |

Agricultural Producers and Processors

- | | |
|---------------------|---|
| Problems | <ul style="list-style-type: none"> - Availability and affordability of liability insurance, especially for catastrophic property damage. - Availability and affordability of environmental impairment insurance coverage. |
| Consequences | <ul style="list-style-type: none"> - Severe financial crunch. |
| Proposals | <ul style="list-style-type: none"> - Expansion of Farm Mutual capacity together with the government as the reinsurer of the last resort in situations such as the greenhouse disaster. |

Primary Producers, Distributors and Processors

- | | |
|----------------------|---|
| Problems | <ul style="list-style-type: none"> - Availability and affordability of liability insurance especially in respect of environmental impairment and "sudden and accidental" pollution coverage. This affects oil and gas producers, drilling contractors, oil field service and supply operators, chemical producers, pesticide operators, waste managers, transporters of hazardous goods, etc. - Difficulty in complying with mandatory insurance provisions such as Parts (2), (3) and (4) of Section 27 of the <u>Petroleum Resources Act</u>, Regulation 752. This requires a person who is operating a well in a water covered area to have at least \$1,000,000 coverage respectively on damages caused by: (i) the drilling operation; (ii) the production operation; and (iii) the machinery. Other mandatory legislation includes federal and provincial Transportation of Dangerous Goods (TDG) Regulations for a number of specified dangerous goods. - There is no available insurance for underground storage tanks and industrial dumps. - Availability of insurance for volunteers and those providing emergency assistance. |
| Consequences: | <ul style="list-style-type: none"> - Operations continued without insurance coverage. - Termination of operations altogether, particularly by smaller businesses. - Borrowing of funds to pay for vastly increased premiums. - Increased prices to consumer. - Reduced provision of emergency response services. |

Proposals

- Amendment to "Spills Bill" to reduce absolute liability to strict liability.
- Enactment of a variation of good samaritan legislation aimed at protecting emergency response teams when they respond to chemical, petroleum, etc., transportation emergencies. A similar recommendation is currently being made by the federal Advisory Council on the Transportation of Dangerous Goods.
- Much greater focus on risk analysis and risk prevention programs undertaken by the insured, in respect of insurance underwriting and rating practices. At the same time, the regulatory apparatus, adequacies of on-site inspections and so forth under the relevant environmental legislation must be reviewed, particularly in respect of hazardous waste management. Municipalities must be encouraged to review and revise anti-pollution by-laws.
- Consideration of an extension of the concept of the "Spills Bill" liability pool in conjunction with the government as the reinsurer of last resort to assist in the provision of certain forms of environmental impairment liability insurance.
- Encouragement of Environment Canada's proposal that the Canadian Council of Resource and Environment Ministers (CCREM) convene a working group to examine solutions to the availability crunch. Such groups would include representatives of government, the private sector, insurance brokers, insurers, reinsurers and other individual experts. (See August 1985 proposal for Environment Impairment Liability (EIL) Insurance Project.)
- Provisions for mandatory reserves (tax deductible) for major environmental risks.
- Increased use of self-insurance to be encouraged through appropriate amendments to tax and insurance legislation. Consideration to be given to permitting producers such as oil companies to indemnify members of their sales associate network and other non-affiliated companies in the event that they suffer losses for which insurance protection is either unavailable or prohibitively expensive, e.g., coverage for underground tank leaks and other pollution-related exposures. At present, it appears that this may contravene the provisions of sections 1.30, 1.34, 1.55 and 1.56 and penalties under the Insurance Act will be incurred.

Sports and Recreational Groups

Problems

- Availability and affordability of liability insurance.
- Liability insurance costs have risen from 150% to 900% for both provincial and community-based organizations.
- More than 55% of the provincial organizations can no longer obtain participants' liability coverage.
- More than 55% of the municipalities surveyed can no longer provide liability coverage for community groups using public facilities.
- The number of claims filed against provincial sport and recreation organizations over the last three years appears to be less than 10 with the average settlement less than \$1,000. (Two recent claims for \$3.9 million and \$1 million have yet to be resolved.)
- The increase in premium rates and the reduction of coverage has no apparent relationship to the history of claims against the organization concerned.

Consequences

- Severe financial crunch leading to cutbacks on programs or carrying on without insurance.
- Cancellation of sports and recreational activities.
- Inability to attract competent volunteers, staff and card-carrying members.
- The precarious financial position of many sports and recreational groups is described in the brief of the Ontario Sports Medicine and Safety Board as follows:

"Self-generated revenues from registration fees, fund-raising projects, and the sale of technical resources accounts for 35-55% of a typical provincial sport association's operating budget. At the community level this source accounts for 75-80% of their income. The balance is made up of operating grants provided by the Ministry of Tourism and Recreation and lottery funds provided by the sale of Wintario tickets. The latter two sources have decreased in size over the last five years. This has placed additional pressures on volunteer managers of organizations to either increase their revenues from the other limited sources or to cut back on many of their proven developmental programs.

While a few of the larger and higher-profile organizations have adapted to a tighter economic

environment, the majority of the smaller provincial and community groups are struggling just to maintain their basic programs and services.

These organizations are therefore seriously concerned by the turbulence in the liability insurance field and the impact it is having on their ability to continually provide participation opportunities for the citizens of Ontario."

Proposals

The special committee convened by the Ontario Sports Medicine and Safety Advisory Board to report to the Minister of Tourism and Recreation has put forward the following recommendations:

- Increased use of releases by participants in sports and recreation events to limit the liability of the sponsoring bodies. The legal validity and use of release forms for majors and minors must, however, be clarified.
- The concept of a Good Samaritan Law to protect volunteers and their respective organizations from legal action must be given serious consideration.
- Risk management guidelines should be developed for volunteer organizations to minimize the inherent risk associated with the activity.
- More stringent guidelines need to be implemented for determining negligence of sponsoring or sanctioning organizations.
- Consideration needs to be given to modifying the Income Tax Act of Ontario and Canada to exempt the injured from taxes on court settlements.
- Modifications to the Family Law Reform Act should be considered to limit the rights of dependents to claim for damages.
- Pre-judgment interest on settlements can serve as a detriment to early resolution and should be eliminated.
- An independent compensation mediation system, which would remove the dispute from the courts and facilitate a settlement between the plaintiff and the defendant, should be considered for Ontario.
- The practicality and economic feasibility of a no-fault pooled insurance program for sport, fitness and recreation needs to be investigated as an alternative to buying insurance on the open market.

- Limitations on the time period for a plaintiff to initiate legal action should not be extended as they were in Bill 160, 1984.
- Other Proposals
- Increased use of self-insurance, such as by Cooper Canada Limited.
 - The formation of a national insurance pool for sports and recreational groups, sponsored by the federal Department of Sports. This is currently under consideration.

Volunteer Groups, Charitable Organizations, Cultural Organizations

- Problems
- Availability and affordability of liability insurance.
 - Premiums totally unrelated to liability risk, loss experience, etc.
- Consequences
- Severe financial crunch leading to curtailment of programs, etc.
 - Inability to attract competent volunteers, participants, etc.
- Proposals
- Some form of good samaritan legislation. In particular, the St. John Ambulance brief suggested the following:

"That the Ontario Legislature consider the provision of a 'Good Samaritan Law' that would prevent legal action against a person attempting to help another who has received injuries. This legislation exists already in three provinces -- Alberta, Newfoundland, and Saskatchewan -- however, the previous Ontario government has rejected such action. It would provide protection not only for the 14,200 St. John Ambulance Brigade volunteers as they act as Good Samaritans, but also would provide a valuable social goal of encouraging the over eight million Canadians trained in First Aid and Health Care by St. John Ambulance to help their fellow men. Other health-related volunteer organizations would also benefit from this legislation, including: the Heart & Stroke Foundation, the Royal Lifesaving Society, and the Red Cross."
 - Civil justice reforms to moderate awards and settlements.
 - Some form of rate regulation or review to ensure that premiums properly reflect the liability risk.
 - Improved statistical base.

Entertainment Industry

- | | |
|---------------------|--|
| Problems | <ul style="list-style-type: none"> - Availability and affordability of liability insurance. - One rock band's premium for a 55-concern excursion increased from \$2,450 to \$27,000, an increase of over 1,000% for less coverage. - Theatres no longer providing insurance to touring companies. |
| Consequences | <ul style="list-style-type: none"> - Increased ticket prices. |
| Proposals | <ul style="list-style-type: none"> - Self-insurance for theatre owners. - Captive insurance. - Civil justice reforms to moderate size of awards and settlement. |

Purchasers of Personal Automobile Insurance

- | | |
|---------------------|--|
| Problems | <ul style="list-style-type: none"> - Affordability, sudden increases in premiums. - High premiums for young male drivers. - Too many drivers forced to Facility Association. - Linking of premiums for close relatives. - Lack of integrated statistical basis to permit ready access to drivers' records, insurance information, etc. - Too easy to cancel insurance. |
| Consequences | <ul style="list-style-type: none"> - More uninsured motorists. - Insureds' revolt. |
| Proposals | <ul style="list-style-type: none"> - No-fault insurance, for both bodily injury and property damage or bodily injury only. - Elimination or substantial modification of age, sex and marital status distinctions for setting premiums. - Government to assist in establishing an integrated data base and to facilitate more efficient electronic access to Motor Vehicle records in cooperation with the Ministry of Transportation and Communications. - Rate regulation. - Government insurance. |

Purchasers of Personal Property Insurance

Problems

- Household Insurance: The Homeowners' Policy is virtually incomprehensible to the lay person and the industry provides too little information and advice to the public.

- The brief of the Consumers' Association of Canada referred to the following complaints:

"First is the cost. Some years ago, this policy was sold on a three-year basis and premiums were modest. Now, it requires an annual premium, which has been rising every year, out of proportion to any cost-of-living index.

"Consumers are confused about the pricing and/or coverage of the auxiliary items in the policy. For example, 'contents' coverage is usually expressed as a percentage of the value of the house. Some people complain that their contents are thus greatly over-valued, not realizing that the figure mentioned does not necessarily represent the true value of those contents, but simply the maximum amount the company will pay in the event of a loss. The 'Optimal Loss Settlement' clause, more properly re-named the 'Co-Insurance' clause, is also badly misunderstood.

"The charge for 'outbuildings', or 'Detached Private Structures', dismays people who have no separate garage or other structure on their property, while others who may have several outbuildings, are under-insured."

Consequences

- Source of irritating confusion for consumers.

Proposals

- The Insurance Bureau of Canada, in conjunction with the Insurance Brokers' Association of Ontario, should review the Homeowners' Policy with a view to simplifying it further for the benefit of all consumers.

Purchasers of Commercial Vehicle Insurance

- Taxis
- Buses, motor coaches
- Trucks, Movers, etc.
- Rent-A-Car fleets

Problems

- Affordability, sudden unjustifiable increases in premiums.
- Poor statistics
- Sudden mid-term cancellations of coverage
- Too many forced to go to the Facility Association

- Substantial surcharge for vehicles entering the United States
 - "Spills Bill" legislation
- Consequences**
- Businesses in severe financial difficulties; some closing down.
 - Substantial interim rate increases for bus fares, etc.
- Proposals**
- No-fault insurance, for both bodily injury and property damage, or bodily injury only.
 - Government to assist in establishing an integrated data base.
 - Regulations to be issued prohibiting mid-term cancellations and setting minimum periods of notice for non-renewals, premium increases, etc. Many groups and individuals suggest a 90-day period.
 - Rate regulation.
 - Exemption from the "Spills Bill" legislation with respect to responsibility for environmental restoration.

APPENDIX 19

GOVERNMENT INSURANCE CORPORATIONS

The terms of reference of the Task Force require consideration of the option of the establishment and operation of a government insurance corporation in Ontario. Even if that request had not been specified, any fair-minded consideration of optional structures of general insurance arrangements for Ontario would have to consider such matters, given the operation of well-established government insurance corporations in four Canadian provinces: Saskatchewan, Manitoba, British Columbia and Quebec.

Some Preliminary Distinctions

Before discussing the main question, some preliminary observations about the real matters at issue, as distinct from superficial issues, are in order. The **first** distinction is that, even if a more nearly complete no-fault system is introduced for certain lines of insurance (e.g., for various risks associated with automobiles), it is not at all necessary to have a government insurance corporation to deliver such a program. In many U.S. states where the balance between no-fault and tort approaches to compensation for automobile accidents is tilted further toward no-fault than in Ontario, delivery is through private insurers. **Secondly**, while there are some generalizations which apply to government enterprises in any or all lines of insurance, many issues are product specific. The pros and cons, the problems and issues are somewhat different for government programs related to bodily injury arising from the use of automobiles than they are for programs dealing with property damage, and different again for various lines of liability insurance. Broadly speaking, government insurance corporations in Canada (aside from workers' compensation) have achieved a higher degree of success in insurance against occurrences of bodily injury from the use of automobiles, and a lower degree of success in general liability and casualty insurance, with some other lines falling in between these extremes.

The **third** distinction concerns good and poor performance of government enterprises. Among government enterprises in Canada, there are and have been both good performances and poor performances judged by tough economic and social criteria. There are strengths as well as inherent weaknesses in the use of the government enterprise form of organization, but there are inherent weaknesses in private enterprises too. If government enterprise is the chosen vehicle to carry on some activity, (e.g., telecommunications services, electricity generation and distribution, fundamental scientific research) then it is important to obtain good performance rather than mediocre or bad performance. That goal involves arrangements to overcome or limit some of the general weaknesses of the government enterprise form of organization. But it also involves specific criteria and arrangements appropriate for the line of activity carried on. From observations of the performance of government insurance corporations in Canada, a number of guidelines emerge to which Ontario should pay attention if it chooses to use a government insurance corporation to carry on some lines of property and casualty insurance.

The **fourth** distinction is that even if the government enterprise form is used for some property and casualty insurance activities in Ontario, it is highly probable that much of such insurance activities will continue to be carried on by private arrangements, albeit regulated by governments.

General Issues Regarding the Use of Government Enterprises for the Production and Distribution of Goods and Services in Canada

Government enterprises, even when they have a strong commercial mandate, are almost always expected to carry out some "social missions". A government telephone company is expected to provide cheap service to remote areas or to elderly citizens and to cover the extra costs out of the rates for other services. A government airline is expected to provide services to remote areas, covering the extra costs out of rates charged for services in dense traffic patterns. An electricity generating and distribution corporation is expected to provide cheap power to industry in remote areas to promote regional development, recovering the subsidy from rates in prime markets. A government enterprise is expected to be a model in affirmative action programs to promote important social goals.

That government enterprises have mixed objectives is a fact of life; it has always been so and will likely continue to be so. But that makes it difficult to evaluate the commercial effectiveness of government enterprises. The personal belief of the Chairman of the Task Force is that there is almost always a tendency toward a creeping expansion of the social objectives in competition with the commercial objectives in government enterprises. It is essential that, if Ontario is to embrace government enterprise for some insurance activities, it make explicit and then evaluate the success and cost of achieving the social missions which will be attached to such an activity. It must also find ways of reconciling the social and the commercial missions which such a corporation might be given. Such guidelines and results must be stated clearly and be available to the general public as accountability to the public is critical.

Government enterprises have to be accountable to the public through governments. Both good and bad consequences follow from that fact. On the "good" side, there is greater openness of accountability and better evaluation of social performance in government enterprises than in private ones. On the "bad" side, short-term political expediencies often are given a heavy weight. Ministers hate to admit that something for which they are responsible has performed badly. The search for debating points is continuous, favourable ones for a government, unfavourable ones for the opposition. Also found on the bad side is the tendency toward a bureaucratic mind-set of the controllers and middle management of government enterprises.

If the Government of Ontario uses the government enterprise form for some general insurance activities, it will be extremely important that tough-minded independent accounting and actuarial audits be carried out, and the medium- to longer-run performance of the enterprise be examined periodically by select committees of the legislature.

Government enterprises, even if only marginally "in the black", tend to be perpetuated, though by any reasonable comparative standards of effectiveness in the use of capital they may be poor performers. There is a much greater tendency even for government enterprises that are "in the red" to be kept alive than for private enterprises.

Government enterprises generally do not pay corporate income taxes, either federally or provincially, although there are exceptions. The tax advantage of government enterprises over private ones, however, should not be exaggerated, because most business corporations pay rather little corporation tax, despite the appearance of taxability as judged by the text book story of tax rates.

Specific Insurance Issues Regarding Government Insurance Corporations

In their commercial operations, government insurance corporations have evolved into being more alike than different from private insurers. They undertake to pay a set of future claims to be established by experience; they collect premium income in advance; they earn investment income on their reserves and on the funds built up from premium income being received in advance of payments of claims; they incur the same kinds of transactions costs, though perhaps on a different scale from private insurers; they engage in reinsurance activities.

How may they differ from private insurance corporations? **First**, the bottom line for government insurance corporations is usually the requirement of breaking even, of showing no profit. As already noted, none of them pay corporate income taxes, federally or provincially. In fact, all of the government insurance companies in Canada aim to be moderately profitable and to retain the profits in the corporation. This practice has arisen among the companies in Western Canada, after each experienced losses that had to be met by the infusion of capital from their governments. Accordingly, each aims to avoid going back to its government for further infusions of capital. The only way to avoid such a situation is to build up capital within the corporation, usually under some such heading as a rate stabilization reserve. On average, those reserves are intended to grow, which can only happen if, on average, premium plus investment income exceeds claims paid plus contributions to claims reserves plus transactions costs.

The policy issues for Ontario, if it opts for a government insurance corporation, are as follows: What initial capital is to be put into the corporation? What investment policy is to be pursued by the corporation? What profit targets and retained profit policy is to be followed? What (if any) return is to accrue to government from the profits of the corporation? And, finally, if the rules allow the corporation to accumulate profit, how will that be done and what will be the rules governing a rate stabilization fund if one is established?

A **second** possible difference is in the time-horizon over which premium adjustments may be made. For La Régie de l'assurance automobile du Québec, premium adjustments have been more gradual than in comparable private sector auto insurance for bodily injury. La Régie appears to take a medium-term horizon in determining and adjusting its rates. There has also been somewhat greater stability over time in automobile insurance rates for the other government insurance corporations than is typical for the private industry in Canada. It is not at all clear that the average changes over time are all that different when the factors in each government corporation are made comparable, but short-term variations in premiums appear to have been smaller for the government corporations. This must reflect a somewhat longer horizon in rate management.

A **third** difference is that each of the government insurance corporations carries out some "social missions". These missions are often rationalized as the quid pro quo for the grant of a monopoly, or for the non-profit, non-taxable treatment of the corporations by their government owners.

A **fourth** difference is alleged, that is, that the transactions costs of government insurance corporations are lower than their private sector opposite numbers. This implies that a larger proportion of the revenue dollar (premiums plus investment income) will find its way into claims paid than in private

insurance corporations. In evaluating this contention it is important to compare "apples with apples", but it is very difficult to do. The book of insurance business differs among the government insurance corporations and differs from that of many individual private insurers in Ontario. No-fault compensation arrangements differ. Attitudes toward suing people appear to be different in Manitoba and Saskatchewan than in British Columbia and Ontario. Distribution and commission arrangements differ. The considered judgment of the Chairman of the Task Force is that for comparable insurance transactions, particularly for compulsory automobile insurance, the transactions costs of the government insurance corporations have taken a somewhat lower proportion of the revenue dollar in recent years.

A **fifth** difference is in the management of the investment portfolio of the government corporations. All of them have substantial investment portfolios, mainly arising from claims reserves, unearned premiums and other reserves. In Manitoba and Saskatchewan, the investment portfolio is specific to the corporation, but managed by the provincial treasury. There is a bit of a bias toward investment in municipal and school board securities from within the province, and provincial government and utility debentures. In British Columbia, the ICBC manages the investment portfolio itself, but again with a bit of a preference for provincial bodies or subordinates, including municipal financing. In Quebec, the portfolio is part of a Caisse du dépôt pool, managed by the Caisse du dépôt.

For all four of the government insurance corporations, there thus appears to be a bias in favour of the securities of provincial governments or their subordinates, and less than usual basket clause investment in private property or equities, as compared with private sector general insurance companies.

If Ontario were to go the route of a government insurance corporation, it would have to decide what the reserve policy is to be, who is to manage the investment portfolio, and what guidelines are to be imposed on the portfolio management. In my view, the primary objectives in the management of such a portfolio should be the safety of and the benefits to insureds, rather than the financial ease of the provincial governments or their subordinates, such as crown corporations or municipalities.

Specific Activities of Government Insurance Corporations

Government insurance corporations have been most successful in basic bodily injury and property damage coverage related to the use of automobiles. The basic coverage for both of these is a government corporation monopoly operation in Manitoba, Saskatchewan and British Columbia; in Quebec the monopoly is limited to bodily injury. The governments have turned out to be relatively efficient providers of these basic insurance services. In Quebec, while the government corporation is not in the property damage business, the government has animated the development of the *Groupeement des assureurs automobile* as a co-operative private sector vehicle which in turn has some responsibility for the Quebec version of the Facility Association.

All three of the western government insurance corporations have eliminated rate classifications based on age, sex and marital status. All have some version of adjustment of insurance premiums on the basis of

accident and driving infringements. The British Columbia system has the steepest penalty increments, which are fully integrated with a comprehensive data base on accidents, infringements, licence status and insurance.

The three western government insurance corporations have all been in the non-auto general insurance business at one time or another, but British Columbia has recently sold off this part of the ICBC operations. The general insurance business has been a less happy experience for government corporations and their government owners than the auto insurance business. The Saskatchewan corporation has been in the general insurance business since the end of World War II, aiming to meet the special needs of Saskatchewan, particularly, of rural Saskatchewan, which it was alleged were either not being met or only being met at exorbitant rates by private insurance organizations. In general, the business has not met its costs easily. The government corporation has been expected to cover difficult risks at low rates. Reinsurance, both in ceding and accepting, has been an unstable experience, at times involving substantial losses. The Manitoba Insurance Corporation was asked to take on difficult pieces of general insurance business in the hard market cycle of the 1970s; it too, has had a rocky road in covering its costs, and has had losses in the reinsurance business. It is now trying to develop a more balanced portfolio of non-auto business, mainly in personal lines in competition with the private insurance companies. It is also trying to balance the financial position of its general insurance activity by integrating the optional auto insurance business. The sale by ICBC of its general insurance business puts an end to its unhappy experience in such lines.

APPENDIX 20

THE FUNDAMENTAL IMPROPRIETY OF INCOME TAX ON PROCEEDS OF LUMP SUM SETTLEMENTS FOR COSTS OF CARE SIMPLIFIED MODEL

By: David W. Slater

1. The central proposition is that, if a flow of future revenue to cover future costs of care is not subject to income tax, then neither should the flow of revenue derived from a lump sum settlement (intended to provide that flow of future revenue) be.
2. Suppose that the future care costs are represented by A B in Figure 1, for period t_0 to t_n , and are intended to be non-taxable; and that the inflation escalation is at $x\%$ per annum.
3. Suppose that the present value of the future care costs, discounted at a tax-free rate of $(x + y)\%$ per annum, yields a lump sum at t_0 of S_0 .
4. Suppose that the revenue stream from S_0 is CD in Figure 1, with OC being initially larger than OA, the difference being used to build up a capital sum; similarly for year t_1, t_2, \dots, t_m . Gradually, the revenue stream and the care cost stream will approach each other, and then cross over.
5. Up to $t = t_m$, the capital sum will build up; thereafter it will decline. Over the actuarial expected life of the arrangement, the cumulation increment of wealth (i.e., the capital sum) will be zero.
6. The cumulative increment of wealth equals zero. The cumulative increment of wealth is, by definition, equal to the cumulative of income over the period, which then is also equal to zero.
7. The integral of the excess of the revenue stream over the cost stream to $t = t_m$ equals the integral of the excess of the cost stream over the revenue stream between $t = t_m$ and $t = t_n$.
8. Since there is no income over the life of the arrangement, there should be no tax over the life either.
9. If the tax authorities treat the excess of the revenue stream over the tax stream in the early years of the arrangement as income for tax purposes, but do not provide refundable transferable tax credits for the period when the revenue stream is less than the cost stream, then they are imposing a net tax over the life of the arrangement, even though there is NO net income and NO NET INCREMENT OF WEALTH.
10. Gross-up is based on the practice set out in number 9. This is a fundamental error in the application of personal income tax. The stylized result is to require a grossed-up income stream EF to yield the after-tax revenue stream CD, and requires a lump sum payment of B, grossed-up from A.
11. Tax should NOT be imposed at all; nor should gross-up, if appropriate definitions of income are applied for tax purposes.

APPENDIX

Figure 1

